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Uzbekistan Primary Health Care Service Availability And Readiness Assessment

SARA REPORT 2026

Ministry of Health of the Republic of Uzbekistan

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UZBEKISTAN PRIMARY HEALTH CARE SERVICE AVAILABILITY AND READINESS ASSESSMENT **(SARA) REPORT 2026**

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EXECUTIVE SUMMARY

362
FACILITIES SURVEYED

14
REGIONS COVERED

24%
OF PUBLIC PHC FACILITIES AT THE ASSESSED LEVELS

±5%
MARGIN OF ERROR ON NATIONAL ESTIMATES

Strong primary health care (PHC) is the foundation of an effective, equitable and resilient health system. As the first point of contact for most people seeking care, it plays a central role in disease prevention, early diagnosis, management of chronic conditions and referral to higher levels of care. Recognising its importance for achieving Universal Health Coverage (UHC), Uzbekistan is implementing major reforms to strengthen PHC services nationwide.

To support these reforms, UNICEF and the Ministry of Health conducted a nationally representative Service Availability and Readiness Assessment (SARA) of public primary health care (PHC) facilities between May and June 2026. The assessment forms part of the WHO/UNICEF Operational Framework for Primary Health Care (2020)[1], which supports countries in monitoring and strengthening PHC systems. Using the WHO SARA methodology[2], adapted to Uzbekistan's health system, the assessment surveyed 362 facilities across all fourteen regions, representing 24% of public PHC facilities at the assessed levels. The sample was designed to provide reliable national estimates of service availability and facility readiness with a margin of error of ±5%. The assessment evaluated both the availability of essential health services and the readiness of facilities to deliver them through adequate infrastructure, equipment, diagnostics, medicines, trained staff and clinical guidelines.

1 WHO/UNICEF Operational Framework for Primary Health Care (2020)https://www.who.int/publications/i/item/9789240017832
2 Service Availability and Readiness Assessment (SARA) | Reference Manual, Version 2.2 (2015) https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)



The assessment demonstrates that Uzbekistan has established a comprehensive primary health care network providing broad access to essential services. Most facilities had the infrastructure, equipment and trained workforce required to deliver routine care, and many core PHC services were widely available throughout the country. However, important gaps in facility readiness continue to limit the consistent delivery of high-quality care. Priority areas for improvement include strengthening infrastructure, expanding access to essential diagnostics and medicines, replacing ageing equipment, and ensuring that health workers have access to updated clinical guidelines – particularly at lower levels.

01
Strengthen facility infrastructure

02
Expand access to essential diagnostics and medicines

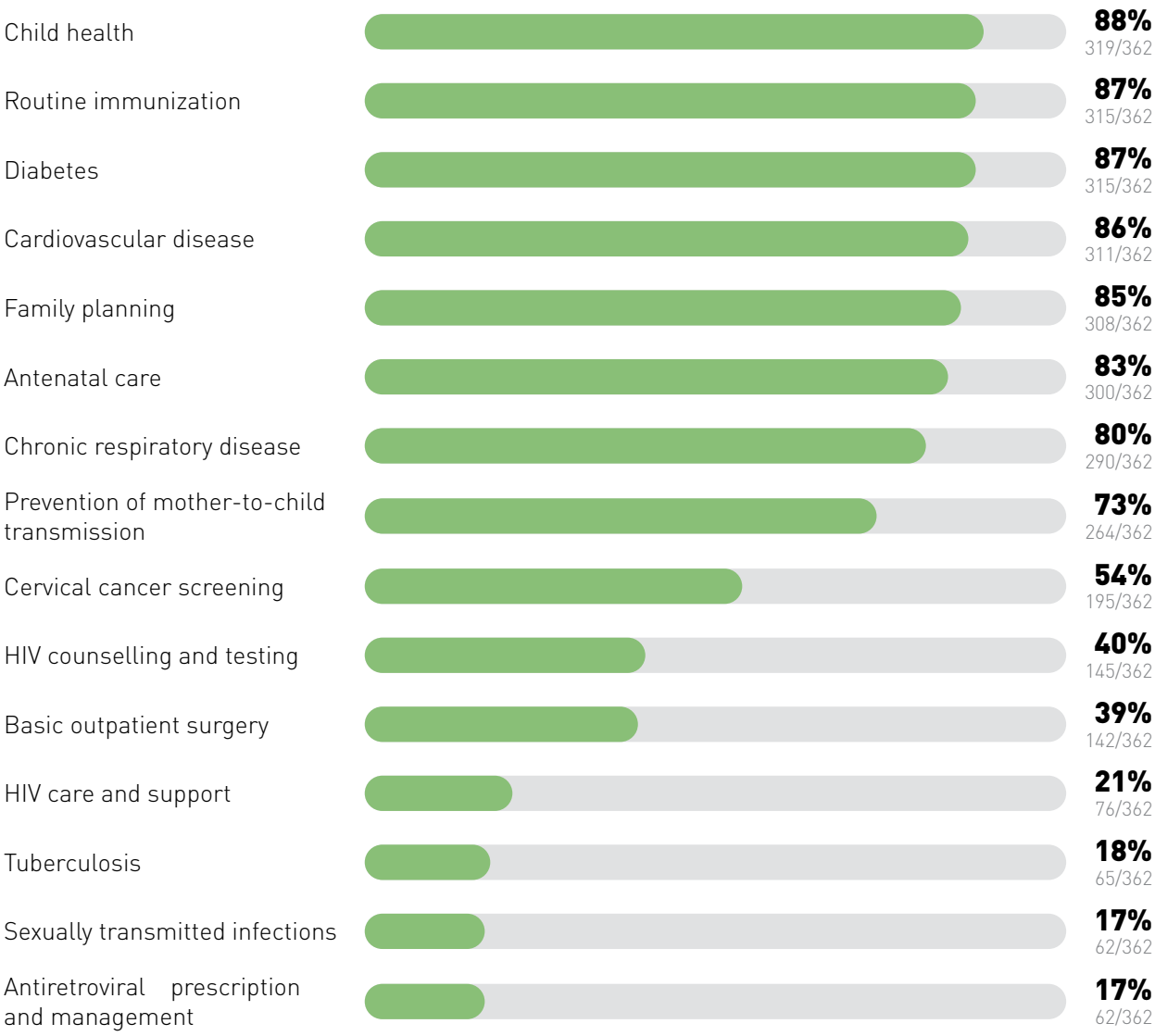
03
Replace ageing equipment

04
Put updated clinical guidelines in every health worker's hands

Key Findings

assessment surveyed **362** facilities

1. Primary health care service availability was generally high across Uzbekistan:

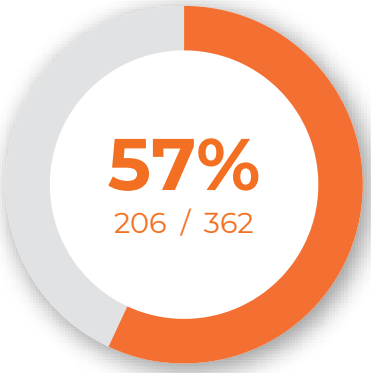


Reflecting Uzbekistan's service delivery model in which these services are intentionally concentrated within higher-level and dedicated facilities rather than family polyclinics.

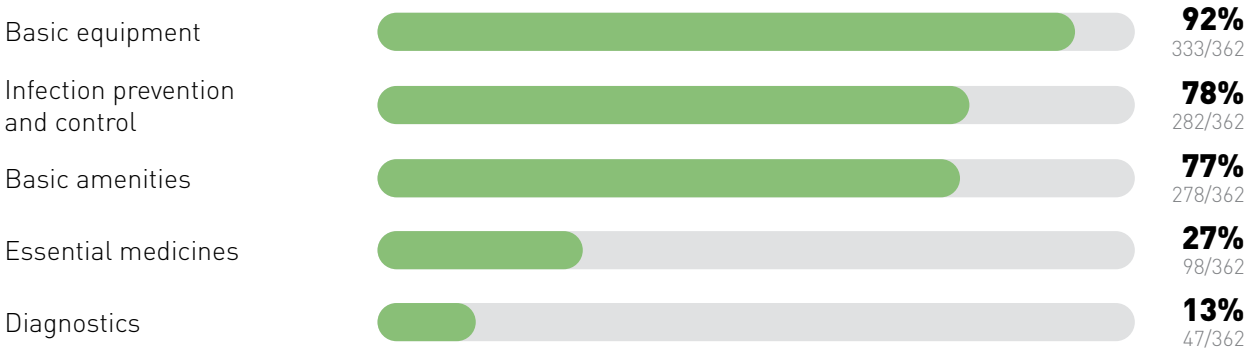
2. Primary health care services are widely available, but facility readiness remains moderate:

despite broad access to essential primary health care services,

National General Service Readiness (GSR) score

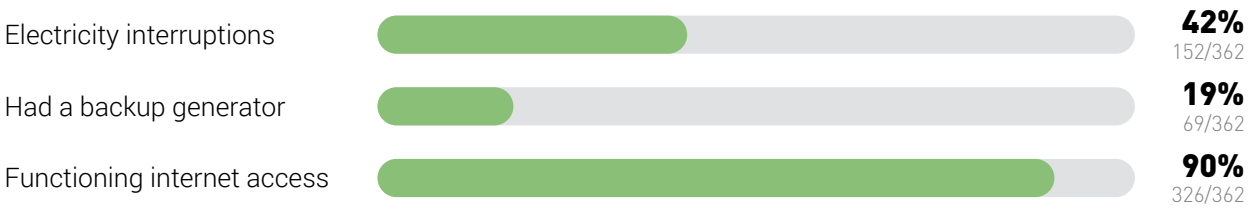


demonstrating that facilities frequently lacked some of the inputs required to deliver services effectively.



3. Strengthening infrastructure remains essential for resilient primary health care:

Reliable electricity, internet connectivity, water supply, sanitation and emergency referral transport remain important constraints for some facilities.



One in eight facilities (12%, 42/362) lacked running water, with ageing infrastructure, low water pressure and inadequate water storage identified as common operational challenges. Despite a high sanitation score with (94%, 340/362) of facilities having at least one improved toilet for clients, fewer than half (44%, 158/362) of facilities had dedicated staff toilets, while almost one-third continued to rely on pit latrines. Strengthening infrastructure and utility resilience will improve service continuity, support digital transformation, and ensure safe, dignified and equitable access to care.

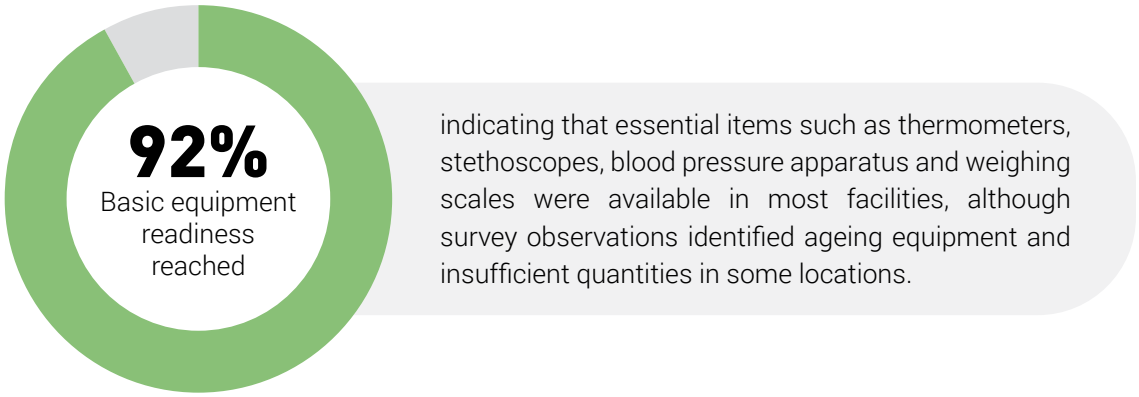
4. Limited access to emergency referral transport may be delaying access to higher-level care:

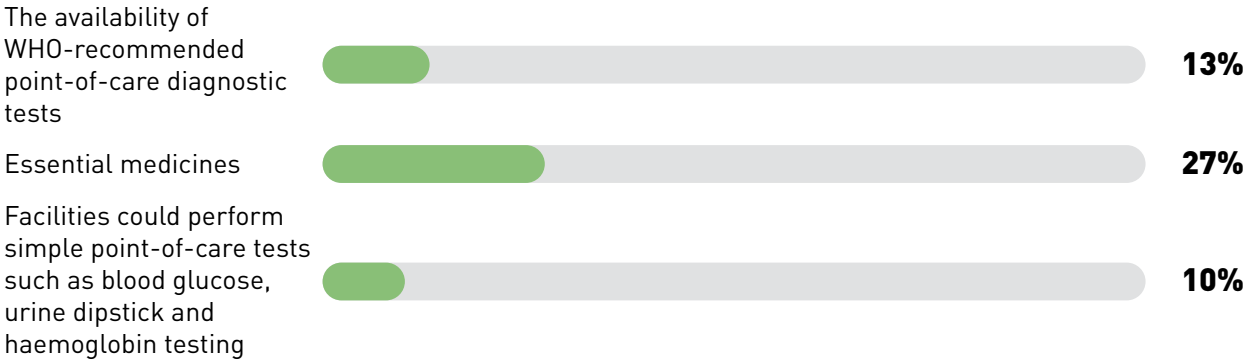
The assessment found



Reliable referral transport is essential for the timely transfer of patients requiring specialist care, including those with trauma, obstetric emergencies, acute cardiovascular events and neonatal complications. Strengthening emergency referral transport would improve the effectiveness and equity of the primary health care referral system.

5. Basic equipment is widely available, but diagnostics and medicines present opportunities for improvement:





Although the assessment did not evaluate Uzbekistan's centralized laboratory network, the WHO SARA methodology considers these basic diagnostics an essential component of facility readiness. Further evaluation of the current diagnostic service delivery model could determine whether selected low-cost point-of-care tests should be provided at primary health care facilities. Likewise, the SARA methodology measures the presence of WHO essential medicines on the day of assessment but does not identify the underlying causes of shortages. Further investigation of procurement, supply chains and stock management could help identify the principal constraints to improving medicine availability. Expanding access to essential diagnostics and medicines, alongside replacing obsolete equipment, would substantially strengthen primary health care at relatively modest cost.

6. Family planning and antenatal care services are widely available, but contraceptive commodities and basic diagnostics reduce readiness:

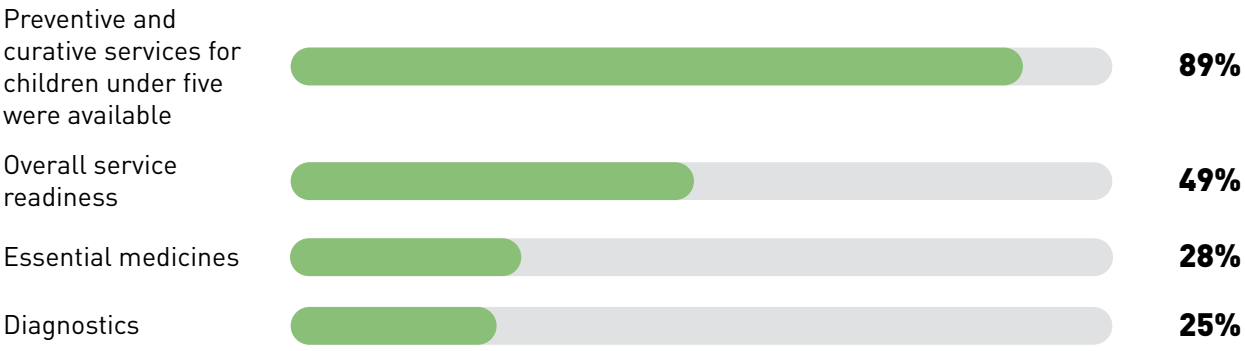


However, readiness was constrained by limited availability of family planning commodities (20%). While injectable contraceptives and intrauterine contraceptive devices (IUCDs) were widely available, oral contraceptive pills, condoms, implants and emergency contraception were rarely stocked. Availability of essential onsite antenatal diagnostics was also low (10%), including lack of onsite haemoglobin and urine protein testing. Type I Family Polyclinics consistently demonstrated the lowest readiness.

7. Routine immunization is the strongest-performing primary health care programme:

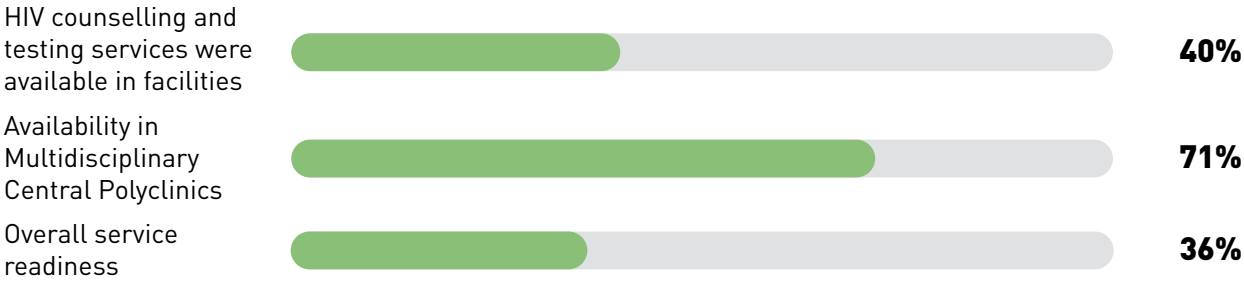


8. Child health services are widely available, but essential medicines and diagnostics remain major constraints:



reduced readiness across the programme, particularly in Type I Family Polyclinics.

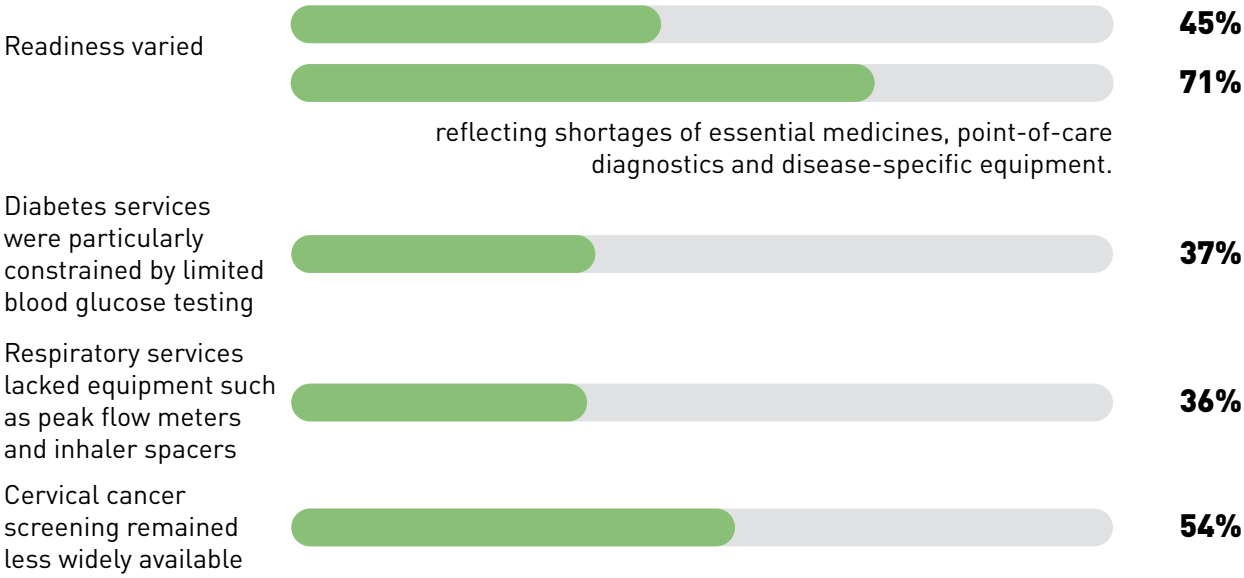
9. HIV service coverage and readiness should be interpreted within Uzbekistan's service delivery model:



primarily due to the limited availability of onsite HIV rapid diagnostic tests and prevention commodities rather than deficiencies in staff capacity. These findings reflect the organisation of HIV services in Uzbekistan while highlighting opportunities to strengthen HIV prevention and confidential counselling within primary health care where appropriate.

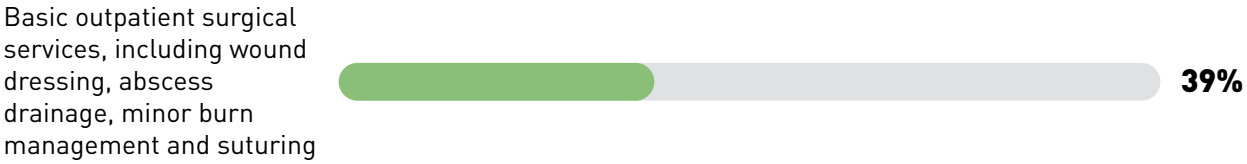
10. Non-communicable disease services are widely available, but diagnostics, medicines and disease-specific equipment constrain readiness

Diabetes, cardiovascular disease and chronic respiratory disease services were widely available across primary health care facilities, supported by trained staff and good availability of basic equipment. However,



owing to limited screening equipment and consumables. Type I Family Polyclinics consistently demonstrated the lowest readiness.

11. Review the delivery model for basic outpatient surgical services:



of surveyed facilities - consistent with the current service delivery model. The Ministry of Health may wish to review whether selected minor surgical procedures could be delivered more widely through primary health care to reduce patient travel and strengthen continuity of care. Where these services are provided, improving equipment, medicines and consumables would strengthen readiness.

12. Staff training is a strength, although doctor recruitment remains challenging:

Most facilities reported recent refresher training and the availability of national clinical guidelines, providing a strong foundation for quality service delivery.



Six facilities reported having no doctors in post, indicating persistent challenges in recruiting and retaining medical personnel in some areas.

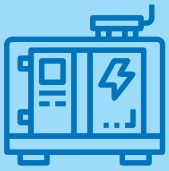
Priority Actions

The assessment identified several priority areas for investment to strengthen primary health care readiness in Uzbekistan:

Backup power:

Develop a national programme to strengthen electrical resilience by prioritising appropriately sized backup generators for high-workload facilities and facilities with frequent power interruptions, together with sustainable fuel and maintenance arrangements based on historical power outage data.

Only **19% (69/362)** of facilities had a backup generator



of which half **(46% 32/69)** were undersized of less than 3kVA.

It is estimated that at least 400 diesel generators between 30kVa and 100 kVa are required.

Internet connectivity:

Achieve universal internet connectivity across all primary health care facilities, beginning with facilities identified without connectivity during the assessment and prioritising Multidisciplinary Central Polyclinics. Reliable electricity should be ensured to support uninterrupted digital health services.

10% (35/362) of facilities had no internet on the day of the visit. It is estimated that at least 100 GSM or satellite internet routers are required.

Water

Investigate facilities that had no water supply at the time of the assessment. Prioritise investment in reliable water infrastructure, including rehabilitation of ageing pipework, improved water storage capacity and measures to ensure continuous water supply for infection prevention and clinical care.

12% (42/362) of facilities had no water at the time of the assessment. It is estimated that at least 120 complete water system rehabilitations are required.

Sanitation

Increase the number of patient and staff toilets, prioritising high-volume facilities with low coverage (MCPs), then facilities where staff have no designated toilets, while progressively replacing pit latrines with improved sanitation facilities that comply with national standards including construction of accessible toilets for elderly patients, pregnant patients, and persons with disabilities.



(23/362) no functioning toilets for clients



(107/362) relied on pit latrines



(204/362) did not have dedicated toilets for staff



(122/362) lacked sufficient toilets.

It is estimated that at least **2,000** additional new toilets are required.

Emergency referral:

Strengthen emergency referral systems by improving access to dedicated referral transport or formal agreements with nearby ambulance services, particularly for facilities serving remote populations.

37%
(134/362)



had no access to emergency referral ambulances at either their own facility or one close by.

It is estimated that at least 500 additional referral ambulances are required.

Basic equipment

Basic equipment: Replace ageing equipment, address remaining shortages of essential items and ensure that every consultation room is equipped with the basic equipment required for routine clinical care up to universal coverage. Self-reported equipment gaps by facilities include



4,860 adult scales



4,532 infant scales



3,996 height boards



17,148 thermometers



5,616 stethoscopes



14,828 blood pressure monitors

IPC

Ensure universal access to disposable gloves, soap, chlorine-based disinfectant, safety boxes, and infectious waste bin bags.



3 months stock of IPC supplies should be always guaranteed in all facilities.

Healthcare waste management

Phase out unsafe low-temperature health care waste incinerators in all health care facilities. Move to contracted sharps and infectious waste disposal with close environmental regulation of private sector service providers.



20% (74/362) of facilities were burning wastes.

It is estimated that 300 facilities need support to transition from burning medical wastes to collection by private waste management services.

Onsite diagnostics

Review the national diagnostic service delivery model to determine whether selected low-cost point-of-care tests - including blood glucose strips, haemoglobin and urine dipstick testing - could be moved to the primary health care setting to improve early diagnosis and clinical decision-making.



87% (315/362) of facilities were not carrying out simple diagnostic tests onsite.

It is estimated that the six (6) WHO rapid tests are missing over 1,000 PHCs.

Essential medicines

Review national essential medicine policies, procurement, financing, stock management and distribution systems to identify and address the underlying causes of low medicine availability, taking account of WHO recommendations for essential PHC level medicines. The facilities scored an average of **27%** for the presence of the 25 WHO essential PHC medicines. Consider rolling out the full package to all PHCs.

Family planning and antenatal care

Consider widening the availability of different contraceptive types and increasing access to essential antenatal diagnostics.

19% (69/362)
Combined oral contraceptives were only available

9% (33/362)
progestin only contraceptive pills were only available

4% (14/362)
emergency contraceptive pills were only available

Consider rolling out the full package to all PHCs.

Immunization

Strengthen cold chain monitoring, ensure consistent refrigerator temperature control and achieve universal availability of auto-disable syringes to further improve immunization service quality and safety.



4% (12/362)
of refrigerators were non-functional



6% (17/362)
of facilities offering immunization services did not have a refrigerator

It is estimated that at least **80** additional vaccine fridges are required. **37% (118/317)** were missing continuous temperature monitors. It is estimated that at least 500 are required.

Child health

Improve access to essential child medicines, point-of-care diagnostics and Integrated Management of Childhood Illness (IMCI) resources, particularly in Type I Family Polyclinics. The facilities scored an average of **28%** for the presence of the 7 IMCI medicines. Consider rolling out the full package to all PHCs offering preventative and curative care to children under five.

HIV

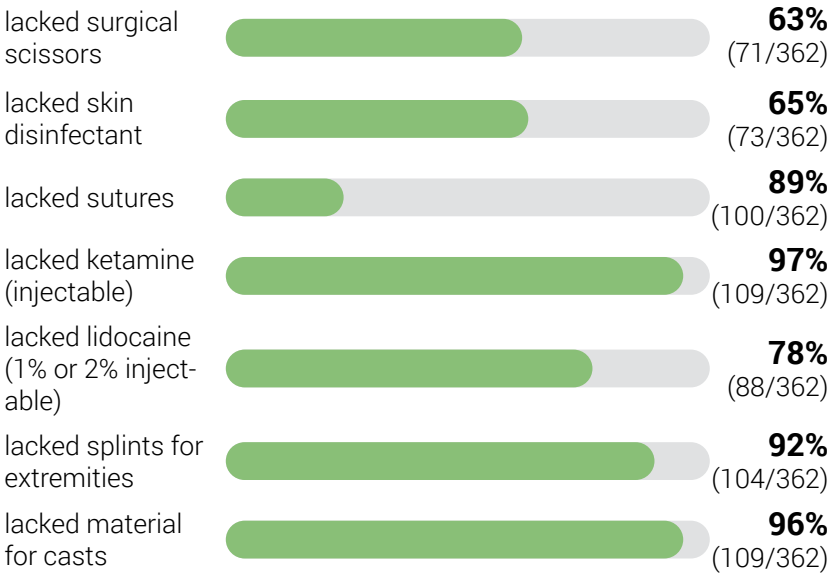
Continue strengthening referral pathways and collaboration between primary health care facilities and specialised HIV services, while expanding confidential counselling and HIV prevention services where appropriate.

NCD

Strengthen primary health care management of non-communicable diseases through improved availability of point-of-care diagnostics, disease-specific equipment and essential medicines, with particular attention to type 2 branch facilities.

Basic outpatient surgical services

Review the current outpatient surgical service delivery model and strengthen the readiness of facilities designated to provide basic outpatient surgical services through improved staff training, equipment and essential consumables.



Consider equipping PHCs with WHO package of basic equipment and consumables.

Workforce training

Continue investing in competency-based in-service training while ensuring that national clinical guidelines remain current, widely available and effectively implemented in routine clinical practice.

Medical workforce

Develop targeted strategies to retain doctors, particularly in underserved areas.



These recommendations provide a practical roadmap for strengthening PHC readiness across Uzbekistan. Addressing the identified gaps would improve service quality, patient and staff safety, infection prevention and control, and continuity of essential health services, while supporting national priorities for digital transformation and health system resilience. Many of the recommended interventions - particularly improvements in diagnostics, essential medicines, water, sanitation and basic equipment - represent relatively low-cost investments with the potential to generate substantial improvements in service readiness and health outcomes. Implementing these recommendations would strengthen service readiness, improve quality of care, enhance patient and staff safety, and increase the resilience of the primary health care system to future public health emergencies and growing demands for digital health services.

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LIST OF ABREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CRD	Chronic Respiratory Disease
CVD	Cardiovascular Disease
FP	Family Polyclinic
GSR	General Service Readiness
HIV	Human Immunodeficiency Virus
IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
MCP	Multidisciplinary Central Polyclinic
MoH	Ministry of Health
NCD	Non-Communicable Disease
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
SARA	Service Availability and Readiness Assessment
TB	Tuberculosis
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. INTRODUCTION

1.1 Background

The Service Availability and Readiness Assessment (SARA)[3], is the World Health Organization (WHO) and UNICEF's standard health facility assessment methodology for measuring the availability of essential health services and the readiness of health facilities to deliver them. As a core component of the WHO/UNICEF Operational Framework for Primary Health Care (2020)[4], SARA provides countries with a standardized approach for identifying gaps in health service delivery, monitoring progress towards Universal Health Coverage (UHC), and strengthening primary health care systems. SARA assesses the availability of health services together with the infrastructure, equipment, medicines, diagnostics, human resources, and clinical guidelines required to deliver those services. In this way, SARA provides evidence to support health system planning, resource allocation and investment decisions. The methodology has been widely implemented internationally and enables countries to benchmark health system readiness using a consistent set of indicators.

In 2026, UNICEF and the Ministry of Health jointly undertook the first nationally representative Service Availability and Readiness Assessment of public primary health care facilities in Uzbekistan. The assessment covered 362 facilities across all 14 regions of the country and provides a comprehensive overview of the availability and readiness of essential primary health care services.

1.2 Assessment objectives

The overall objective of the SARA assessment was to support evidence-based planning and investment to strengthen primary health care in Uzbekistan. The specific objectives were:

- To assess the availability of essential primary health care services across Uzbekistan;
- To evaluate facility readiness through the assessment of infrastructure, equipment, infection prevention control materials, diagnostics, essential medicines, human resources and clinical guidelines;
- To identify strengths and gaps within the primary health care system to inform national planning and investment;
- To establish a national baseline for monitoring progress in primary health care strengthening and support data-driven evidence-based decision-making by the Ministry of Health and development partners.

The assessment was planned, implemented, validated and analysed jointly by the Ministry of Health and UNICEF. Field data collection was undertaken by Ministry of Health personnel, and all survey datasets, photographs and analytical outputs were shared with the Ministry of Health.

3 Service Availability and Readiness Assessment (SARA) | Reference Manual, Version 2.2 (2015) https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)
4 WHO/UNICEF Operational Framework for Primary Health Care (2020) https://www.who.int/publications/i/item/9789240017832

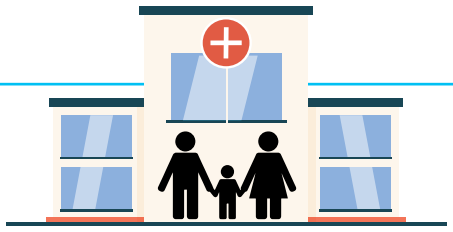
1.3 Overview of Uzbekistan's primary health care system

Uzbekistan is currently implementing a phased reform of its primary health care system as described in Presidential Resolution 88 dated 19.05.2025 https://lex.uz/uz/docs/7534278 and Presidential Resolution 185 dated 19.05.2025 https://lex.uz/uz/docs/7538095. The reforms aim to establish a modern, people-centred PHC system by strengthening family polyclinics as the foundation of health service delivery, bringing essential services closer to communities, improving the quality and efficiency of care, clarifying the roles and responsibilities of different levels of the health system, strengthening the capacity and performance of the health workforce, expanding digital health systems, and introducing new management and financing approaches.

Under Presidential Decree No. PF–88 of 19 May 2025, Uzbekistan is implementing a new model for the organization of the health care system through a phased approach. The reforms were launched on a pilot basis in 15 designated districts (cities) from 1 July 2025 and were expanded to all districts (cities) of Samarkand Region from 1 January 2026.

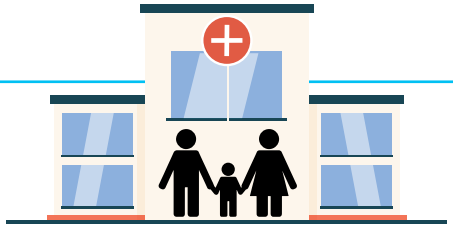
Under the new model, Multidisciplinary Central Polyclinics at district and city level are transformed into consultative and diagnostic departments of the corresponding central hospitals and no longer have populations attached to them for the provision of primary health care services. Primary health care is delivered through Family Polyclinics, staffed by family physicians, paediatricians, obstetrician-gynaecologists, and diagnostic specialists. In addition, inter-district central laboratory services are established to serve hospital departments and Family Polyclinics.

The reforms are being implemented through a phased approach, beginning with pilot districts where new models of service delivery, management, financing, and workforce organization are being tested, refined, and evaluated before being scaled up nationally. During the transition period, facilities operating under the previous organisational model continue to function alongside newly established Family Polyclinic Type I and Type II facilities. Consequently, five categories of public primary health care facilities currently coexist and were included in this assessment.



Family Polyclinic Type I
(MoH Code: 203)
Oilaviy poliklinika 1-tip (203)

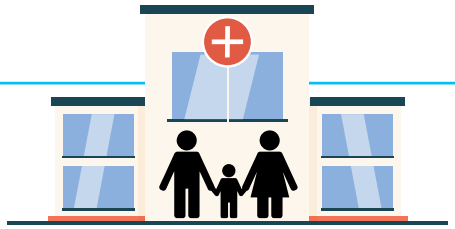
An independent state primary health care institution with legal-entity status, established under the new PHC model to serve an attached population of 3,001–12,000 people. It delivers the guaranteed primary health care package through family medicine teams, including outpatient and home-based care, preventive services, immunisation, screening and early detection, management and follow-up of common and chronic conditions, reproductive and maternal health services, available basic diagnostic procedures, and referral to specialist and hospital care. Type I Family Polyclinics are linked to a designated Type II Family Polyclinic, whose paediatric, obstetric-gynaecological, ultrasound and radiology specialists also serve the population attached to the Type I facility.



Family Polyclinic Type II

(MoH Code: 201)
Oilaviy poliklinika 2-tip (201)

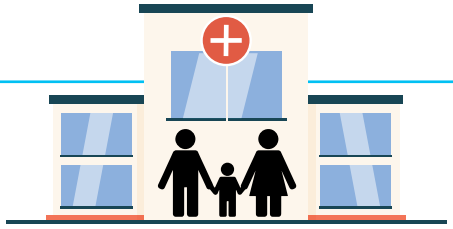
An independent state primary health care institution with legal-entity status, normally serving an attached population of 12,001–51,000 people, with up to an additional 3,000 people permitted depending on geographical conditions. In addition to delivering the core guaranteed primary health care package through family medicine teams, a Type II Family Polyclinic functions as the principal service and clinical-support hub for the Type I Family Polyclinics and branches linked to it. Its paediatrician, obstetrician-gynaecologist, ultrasound physician and radiologist also provide services to the populations of the linked facilities. Type II facilities additionally provide extended-hours duty coverage for the populations served by their linked Type I facilities and branches.



Family Polyclinic

Type II Branch (MoH Code: 202)
Oilaviy poliklinika 2-tip filiali (202)

A local primary health care service unit operating as a branch of a Type II Family Polyclinic and serving an attached population of up to 3,000 people. Branches are established primarily to improve geographical access for remote mahallas located at least five kilometres from an existing Type II Family Polyclinic. A branch provides primary health care to its attached population under the Family Polyclinic Regulation and is expected to include, at minimum, a patient examination room, a treatment/procedure room and a hygiene room. It relies on its linked Type II Family Polyclinic for access to designated specialist services, staff support and extended-hours coverage.



Family Polyclinic
(MoH Code: 210)
Oilaviy poliklinika (210)

A first-contact primary health care facility operating under the previous organisational model and serving an attached population through family medicine and primary care teams. These facilities provide preventive and curative care for common conditions, maternal and child health services, immunisation, health promotion, patronage and home-based care, follow-up of patients with chronic conditions, basic diagnostic services, and referral to specialist or hospital care where required. During the transition period, they continue to operate alongside the new PHC model and are subject to inventory and reorganisation into the appropriate type of Family Polyclinic or branch, based on the size and geographical distribution of the attached population



Multi-Profile Central Polyclinic
(MoH Code: 205)
Ko'p tarmoqli markaziy poliklinika (205)

A district- or city-level specialist outpatient facility operating under the previous organisational model. It provides specialist consultations, diagnostic investigations and referral support, primarily for patients referred from first-contact primary health care facilities. Under the new reform model, Multidisciplinary Central Polyclinics are not retained as independent PHC facilities: in reform areas, they are converted into consultative and diagnostic departments of the corresponding central hospitals, and no population is attached to them for the provision of primary health care.

Table 1: Facility types included in the SARA assessment

2. METHODOLOGY

2.1 Methodology overview

This assessment followed the WHO Service Availability and Readiness Assessment (SARA) Reference Manual (Version 2.2) with adaptations to reflect the organisation of Uzbekistan's primary health care system. Figure 1 provides an overview of the assessment process, from sample selection through data collection, quality assurance and analysis.

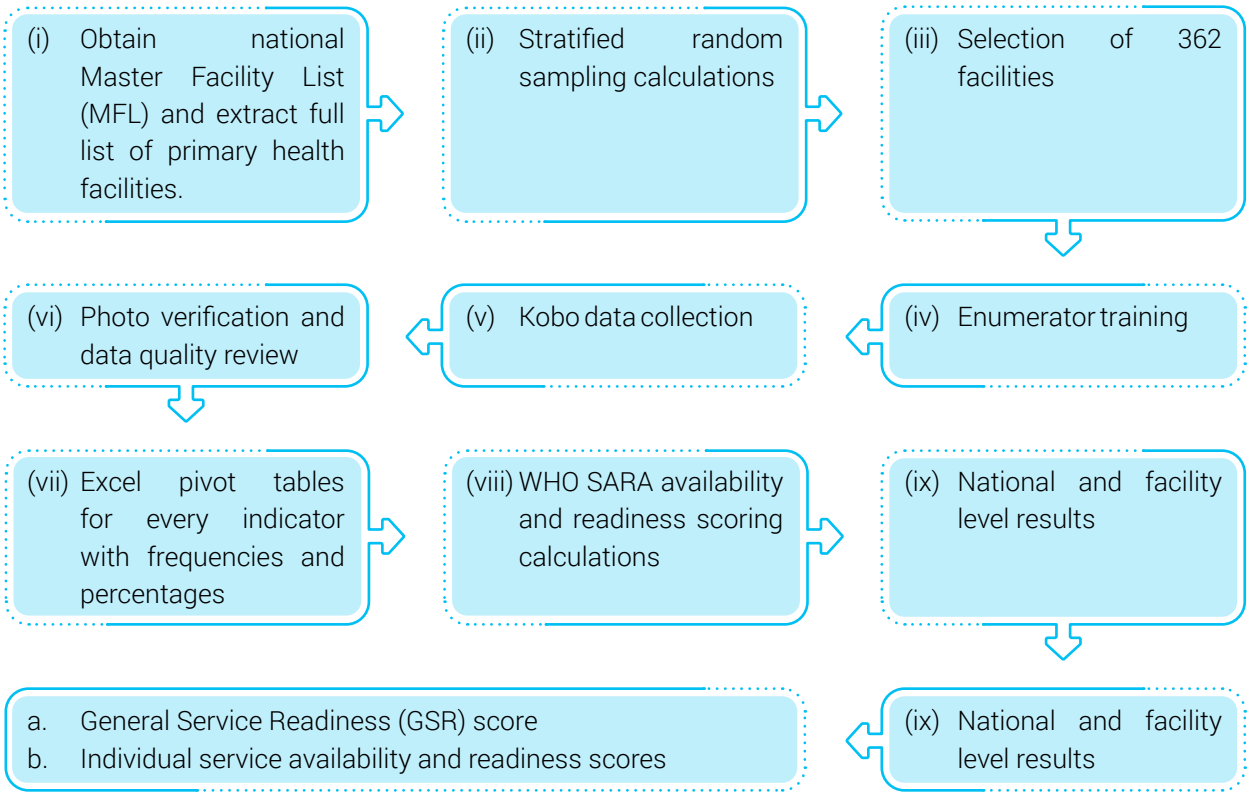


Figure 1. Overview of the SARA assessment process

2.2 Sample size and stratification

The assessment was conducted using a nationally representative stratified random sample of 362 primary health care facilities selected from the Ministry of Health Master Facility List, which comprises 1,520 government-run primary health care facilities across all 14 regions of Uzbekistan. The initial national sample size of 362 out of a total of 1,520 facilities was calculated assuming a 95% confidence level, a margin of error of ±5%, and an expected proportion of 50% (p = 0.5) using the standard formula for an infinite population adjusted for a finite population as follows:

$$n = \frac{n_o}{1 + \frac{n_o - 1}{N}} \quad \text{where } n_o = \frac{Z^2 * p(1-p)}{e^2}$$

Where
n = sample size (adjusted for finite population)
n_o = sample size (infinite population)
N = population size
Z = 1.96 (95% confidence level)
p = 0.5 (50% anticipated prevalence)
e = 0.05 (5% desired margin of error)

The national sample was designed to provide reliable estimates of service availability and readiness at the national level while ensuring representation of all 14 regions and the five primary health care facility types included in the assessment. Sample size was determined by balancing statistical precision with available implementation resources. Facilities were stratified by facility type, and because some facility categories comprise relatively few facilities nationally, proportionally higher sampling fractions were intentionally applied to the smaller strata to improve the precision of estimates and enable meaningful comparisons between facility types.

The final sample included 115 Family Polyclinics, 78 Multidisciplinary Central Polyclinics, 72 Family Polyclinic Type I facilities, 73 Family Polyclinic Type II facilities and 24 Family Polyclinic Type II Branches, representing approximately 24% (362/1,520) of all public primary health care facilities nationwide. Sampling fractions ranged from 12% (115/976) for Family Polyclinics to 75% (24/32) for Family Polyclinic Type II Branches.

The resulting sample achieved an estimated national margin of error of ±5.0%, while the estimated margins of error for individual facility types ranged from ±8.0% to ±10.2% (Table 1).

Facility Type	Total National Facilities	SARA Sample Size	Sampling Fraction	Margin of Error
Family Polyclinic	976	115	12%	±8.6%
Multidisciplinary Central Polyclinic	194	78	40%	±8.6%
Family Polyclinic Type 1	177	72	41%	±8.9%
Family Polyclinic Type 2	141	73	52%	±8.0%
Family Polyclinic Type 2 Branch	32	24	75%	±10.2%
Jami (n = 50)	**1,520**	**362**	**24%**	**±5.0%**

Table 2: Sample used by the SARA tool by facility type

Margins of error for each strata were calculated using standard sample size methodology for finite populations, assuming a 95% confidence level, a 50% response distribution and application of the finite population correction factor.

$$\text{Margin of Error} = z* \sqrt{\frac{p(1-p)}{n}} * \sqrt{\frac{N-n}{N-1}}$$

For example for Family Polyclinic Type I facilities, the total population comprised 177 facilities, of which 72 were sampled. Assuming a 95% confidence level and a 50% response distribution, the initial margin of error is ±11.5%. Applying the finite population correction to account for the high sampling fraction (41%) reduces the margin of error to ±8.9%.

$$\text{Margin of Error} = z* \sqrt{\frac{p(1-p)}{n}} * \sqrt{\frac{N-n}{N-1}}$$

$$\text{Margin of Error} = 1.96* \sqrt{\frac{0.5(1-0.5)}{72}} * \sqrt{\frac{177-72}{177-1}}$$

$$\text{Margin of Error} = 1.96 * 0.0589 * 0.7723 = 0.089$$

2.3 Construction of sampling frame

The sampling frame was constructed using the Ministry of Health Master Facility List, which included all 1,520 government-run primary health care facilities operating at the time of the assessment. Facilities were first stratified by facility type to ensure adequate representation of each category within the final sample.

Within each facility stratum, facilities were ordered and assigned a unique identification number. A random starting point was generated using a computer-based random number generator, after which facilities were selected using a fixed-interval systematic sampling approach. The sampling interval for each stratum was determined by dividing the total number of facilities in the stratum by the required sample size. This approach ensured that facilities were selected randomly while maintaining an even distribution across the sampling frame and reducing the risk of clustering.

The objective of the sampling strategy was to obtain a sample that was as representative as possible of the national primary health care system while maintaining the predetermined sample size for each facility type. Where three selected facilities were temporarily closed, undergoing major renovation or otherwise unavailable for assessment during the survey period, they were replaced with the nearest comparable facility of the same facility type within the same geographical region. This replacement procedure ensured that the planned sample size was maintained while minimising any impact on the representativeness of the survey.

Region	Family Polyclinic	Multidisciplinary Central Polyclinic	Family Polyclinic Type 1	Family Polyclinic Type 2	Family Polyclinic Type 2 Branch	Grand Total
Andijan	8	7	2	10	3	30
Bukhara	11	5	8	6	0	30
Djizzak	4	5	7	3	5	24
Fergana	11	7	4	8	0	30
Karakalpakstan	9	7	4	2	2	24

Kashkardrya	8	6	9	5	3	31
Khorazm	8	6	5	5	0	24
Namangan	4	6	8	8	0	26
Navoi	11	4	8	2	0	25
Samarkand	1	3	9	13	5	31
Surkhandarya	14	5	3	6	3	31
Syrdarya	4	4	4	3	3	18
Tashkent City	11	4	0	0	0	15
Tashkent Region	11	9	1	2	0	23
Grand Total	**115**	**78**	**72**	**73**	**24**	**362**

Table 3: Number and type of facility assessed using the SARA tool by region

2.4 Enumerator orientation and training

To ensure consistent and high-quality data collection, a three-day Enumerator Training Workshop was conducted in Tashkent from 12–14 May 2026 for regional enumerators, representing all 14 regions of Uzbekistan. The workshop was jointly organised by UNICEF and the Ministry of Health prior to the commencement of field data collection.

The training programme was designed to establish a consistent understanding of the WHO SARA methodology, strengthen enumerator competency in the use of the Kobo mobile data collection platform, improve data quality through standardised interpretation of survey questions, and prepare field teams for safe and effective data collection during the national assessment.

The first day focused on classroom-based orientation to the WHO Service Availability and Readiness Assessment (SARA) methodology, including the objectives of the assessment, interpretation of the questionnaire, and standardised procedures for collecting data. Enumerators received detailed instruction on all survey modules, including facility information, infrastructure and general service readiness, service availability, diagnostics, medicines and commodities, and supply chain management. Training also included installation and use of the Kobo mobile data collection platform to ensure familiarity with electronic data capture and submission procedures.

The second day consisted of supervised field practice in primary health care facilities in the Yangiyo'l district of Tashkent Region. Enumerators were divided into four teams and conducted complete pilot assessments in both facilities operating under the previous primary health care model and facilities established under the ongoing primary health care reform programme. The practical exercise provided hands-on experience using the Kobo application, interpreting survey questions, interviewing facility staff, verifying tracer items, and recording observations under field conditions.

The final day was dedicated to structured debriefing and quality assurance. Each field team presented its findings, discussed challenges encountered during the pilot assessments, and agreed on standardised approaches for resolving common interpretation issues. The workshop concluded with a review of the pilot data collected, clarification of outstanding questions, and final guidance on field logistics and data collection procedures before deployment to the regions.

The combination of classroom instruction, supervised field practice and structured feedback helped establish a consistent understanding of the survey methodology, strengthened enumerator competency in electronic data collection, and promoted standardised interpretation of survey questions across all regional teams prior to national data collection.

The data collection period commenced immediately after the training workshop and took three weeks to complete from 18th May to 12th June 2026.



Figure 2. SARA orientation and training workshop for enumerators, Tashkent



Figure 3. SARA orientation and training workshop for enumerators, Tashkent

2.5 Data quality assurance

Ensuring the accuracy, completeness and consistency of data is a fundamental component of the WHO Service Availability and Readiness Assessment (SARA) methodology. To minimise data collection errors and improve data reliability, the assessment employed a multi-layered quality assurance process incorporating electronic data collection, built-in questionnaire validation, photographic verification, field supervision and post-collection data review.

Data were collected electronically using the Kobo Toolbox mobile data collection platform. Compared with traditional paper-based surveys, electronic data collection reduces transcription errors, improves data completeness and allows automated validation of responses at the point of data entry. The electronic questionnaire was developed to closely follow the WHO SARA survey instrument while incorporating several additional validation features to improve data quality during field implementation.

Mandatory response fields were incorporated throughout the questionnaire to ensure that all essential variables were completed before a survey could be submitted. Automated range checks were used for numerical variables to identify implausible values at the time of data entry, while skip logic automatically directed enumerators to relevant sections of the questionnaire based on previous responses, reducing respondent burden and preventing inconsistent or contradictory data.

A key feature of the assessment was the extensive use of photographic verification. Enumerators were required to capture photographs for the majority of survey questions, including infrastructure, medical equipment, diagnostics, medicines, cold chain equipment, infection prevention and control measures, utilities and other tracer items. These photographs provided an objective record of observed conditions, supported verification of questionnaire responses and enabled subsequent review of findings during data cleaning and analysis.

During data collection, completed questionnaires were routinely reviewed as they were submitted through the Kobo platform to identify missing data, inconsistencies and potential reporting errors. Where anomalies or unexpected results were identified, the survey team worked directly with regional enumerators to verify responses and, where necessary, revisit original survey records or supporting photographic evidence to confirm the correct values.

Following completion of fieldwork, all survey data underwent a structured data cleaning process prior to analysis. This included checks for duplicate records, missing values, logical inconsistencies and outlying observations. Apparent data entry errors were reviewed against the original Kobo submissions and supporting photographs, and corrections were made where clear evidence demonstrated that responses had been entered incorrectly. Where clarification was required, enumerators were contacted to verify the original observations before the final analytical dataset was prepared.

The combination of comprehensive enumerator training, electronic data collection with built-in validation, extensive photographic verification, ongoing supervision and systematic post-collection review provided multiple independent layers of quality assurance and helped ensure that the final dataset accurately reflected conditions observed within participating primary health care facilities.

2.6 Adaptation of the WHO SARA methodology for Uzbekistan

Although the assessment followed the WHO Service Availability and Readiness Assessment (SARA) Reference Manual (Version 2.2), the assessment instrument was adapted to reflect the organisation of Uzbekistan's health system. Several standard WHO SARA tracer services were excluded because they are not routinely delivered through the general primary health care system.

In Uzbekistan, services relating to tuberculosis diagnosis and treatment, HIV care and support, antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT) of HIV, Basic Emergency Obstetric Care (BEmOC) and Comprehensive Emergency Obstetric Care (CEmOC) are primarily provided through specialised hospitals, specialised disease programmes or tertiary-level referral facilities rather than Family Polyclinics and Multidisciplinary Central Polyclinics. As these services fall outside the routine scope of primary health care service delivery, they were excluded from the assessment.

In addition, maternal and newborn hospital services, including BEmOC and CEmOC, have recently been comprehensively assessed through the MoH-led Ishonch initiative. To avoid duplication of effort and focus resources on services routinely delivered through primary health care facilities, these service areas were not included in the present assessment.

Consequently, the service availability and service readiness results presented in this report relate only to those tracer services that are routinely expected to be delivered through Uzbekistan's public primary health care system.

Programme Area	SARA Services	Assessed / Not Assessed
Reproductive, Maternal and Newborn Health	S7) Family planning S8) Antenatal care S9) Basic obstetric and newborn care S26) Comprehensive obstetric care	Assessed Assessed Delivered through maternity/ perinatal facilities rather than primary health care
Immunization	S10) Routine immunization	Assessed
Child Health	S11) Preventive and curative care for children under five	Assessed
Communicable Diseases	S15) Malaria S16) Tuberculosis diagnosis and treatment S17) HIV counselling and testing S18) HIV/AIDS care and support services S19) ARV services S20) Prevention of mother to child transmission S21) Sexually transmitted infections	Not relevant Delivered through specialised TB services Assessed Delivered through specialised HIV/ AIDS services
Non-Communicable Diseases	S22) Diabetes Diagnosis and Management S23) Cardiovascular Disease S24) Chronic Respiratory Disease S29) Cervical Cancer	Assessed Assessed Assessed Assessed
Surgical Services	S25) Minor outpatient surgical procedures S27) Blood transfusion S28) Comprehensive surgical services	Assessed Delivered through secondary and tertiary hospitals rather than primary health care facilities

Table 4: Primary health service areas assessed by SARA.

2.7 Data management

The cleaned dataset was analysed using Microsoft Excel. Pivot tables and summary statistics were used to calculate frequencies, percentages and readiness scores by facility type, region and tracer service. General Service Readiness (GSR) domain scores and service-specific availability and readiness scores were calculated in accordance with the WHO Service Availability and Readiness Assessment (SARA) Reference Manual (Version 2.2).

In addition to the standard WHO SARA indicators, the electronic questionnaire collected supplementary information on the quantity, condition and functionality of selected equipment, together with additional infrastructure and service delivery variables relevant to the Uzbekistan health system. These supplementary variables were analysed separately to provide additional context for interpreting the results but were not included in the calculation of WHO SARA readiness scores.

The final analytical dataset was used to generate the tables, figures and dashboards presented throughout this report, providing national estimates together with disaggregated analyses by facility type and region.

2.8 Data analysis and SARA scoring

The WHO SARA methodology produces two principal outputs:

(i) General Service Readiness (GSR) and
(ii) Individual Service Availability and Readiness.

2.8.1 General Service Readiness (GSR)

In accordance with the WHO Service Availability and Readiness Assessment (SARA) Reference Manual (Version 2.2), the General Service Readiness (GSR) Score is calculated from five equally weighted readiness domains that measures the overall capacity of a health facility to deliver routine health services by assessing the availability of fundamental domains including:

(i) Basic Amenities (e.g. power, water, sanitation and communications);
(ii) Basic Equipment (e.g. scales, stethoscopes and thermometers);
(iii) Standard Precautions for Infection Control;
(iv) Basic Diagnostic Tests (e.g. haemoglobin and glucose);
(v) Essential Medicines necessary to support service delivery.

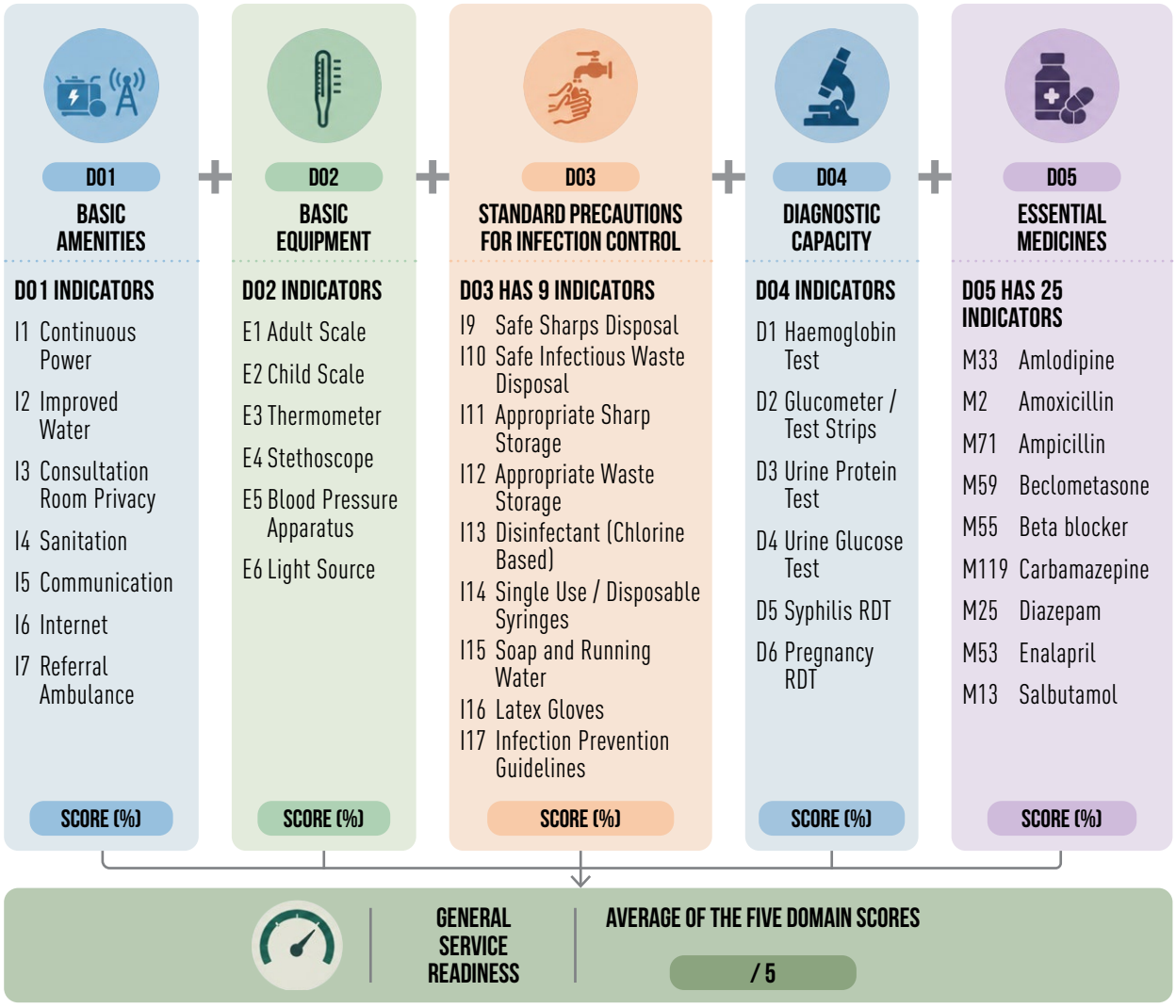


Figure 4. The five (5) General Service Readiness domains and their tracer indicators

Each domain consists of a predefined set of tracer indicators that represent the minimum resources required for routine service delivery. Each tracer indicator is recorded as a binary variable, indicating whether the required item was available and functional on the day of the survey (Yes = 1; No = 0). The domain score is then calculated as the percentage of tracer indicators available within that domain.

Formula:

$$\textbf{GSR}\ (\%) = \frac{D01 + D02 + D03 + D04 + D05}{5}$$

where:
D01 = Basic Amenities
D02 = Basic Equipment
D03 = Standard Precautions for Infection Prevention and Control
D04 = Diagnostic Capacity
D05 = Essential Medicines

General Service Readiness is calculated for all surveyed primary health care facilities, regardless of facility type or level providing an indicator of the overall readiness of the primary health care system to deliver services. The General Service Readiness Score is calculated as the arithmetic mean of the five domain scores. A higher score indicates that facilities possess a greater proportion of the essential inputs required to deliver primary health care services.

Each domain contributes equal weight (i.e. 20%) to the overall General Service Readiness Score, irrespective of the number of tracer indicators within that domain. This weighting follows the WHO SARA methodology and ensures that each of the five core components of health facility readiness contributes equally to the overall assessment.

2.8.2 Service availability

In addition to General Service Readiness, the SARA assessment evaluated the availability and readiness the following primary health care services.

- S7) Family planning
- S8) Antenatal care
- S10) Routine immunization
- S11) Preventive and curative care for children under five
- S17) HIV counselling and testing
- S22) Diabetes Diagnosis and Management
- S23) Cardiovascular Disease
- S24) Chronic Respiratory Disease
- S29) Cervical Cancer
- S25) Minor outpatient surgical procedures

Service availability measures whether services are offered by facilities but provides no information regarding the capacity of those facilities to deliver the service according to WHO standards. Service availability was calculated as the proportion of surveyed health facilities that reported providing a specific health service at the time of the assessment. The denominator includes all facilities surveyed, regardless of whether they provide the service.

The Service Availability Score was calculated as:

Formula:

$$\textit{Service Availability Score (\%)} = \frac{\textit{Number of facilities offering the service}}{\textit{Total number of facilities surveyed}} * 100\%$$

For example, if 300 of 362 facilities reported providing routine immunization services, the service availability score would be 83% (300/362).

This indicator measures the geographical availability of health services but does not assess the readiness of those facilities to deliver quality services.

2.8.3 Service readiness

Service readiness assesses the capacity of facilities already providing a service to deliver that service according to WHO minimum standards. Unlike service availability, only facilities that reported providing the service are included in the calculation.

Each service consists of several readiness domains containing tracer indicators. Depending on the service assessed, these domains may include:

- Staff and guidelines;
- Equipment;
- Diagnostic capacity (where applicable); and
- Medicines and commodities.

Within each domain, each tracer indicator is scored as Available = 1 or Not Available = 0. Domain scores are calculated as the percentage of tracer indicators available within each domain. The overall Service Readiness Score is then calculated as the arithmetic mean of the applicable domain scores, with each domain contributing equally regardless of the number of tracer indicators it contains.

For example, for S10) Routine Immunization there are three (3) applicable domains each with the following set of tracer indicators.

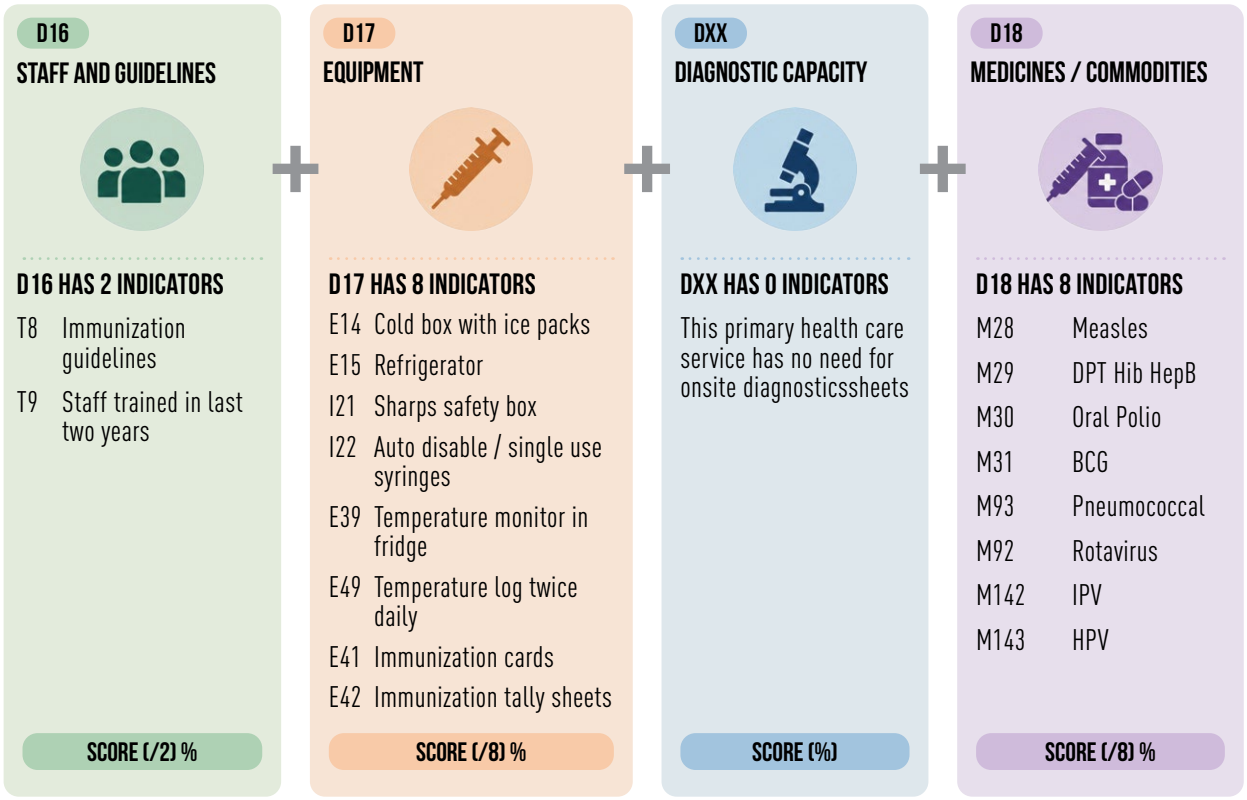


Figure 5. Example service readiness tracer indicators

For routine immunization, the Service Readiness Score is therefore calculated as:

Formula:

$$\text{Service Readiness (\%)} = \frac{DO16 + DO17 + DO18}{3} * 100\%$$

The resulting Service Readiness Score reflects the average availability of the essential resources required to deliver that service among facilities that provide it.

2.9 Methodological limitations

As with any health facility assessment, the findings of this survey should be interpreted in light of several methodological limitations inherent to the WHO Service Availability and Readiness Assessment (SARA) methodology.

SARA provides a snapshot not a continuum view: The assessment measures the availability of tracer items on the day of the survey and therefore provides a cross-sectional snapshot of facility readiness at a single point in time. It does not assess the continuity of service availability throughout the year. Consequently, temporary stock-outs, equipment failures or periodic service delivery may influence readiness scores, even though routine availability may differ over time. An example of this is immunization services, some inputs may only be delivered when vaccine supplies are received, meaning their availability on the survey day may not fully reflect routine service provision.

SARA measures the presence of inputs onsite on the day of the survey and is not designed to capture services that are referred e.g. diagnostics: The WHO SARA methodology assesses the capacity of individual health facilities to provide services on-site. Consequently, in health systems where selected services are intentionally centralised through referral networks or specialised facilities, readiness scores may underestimate service accessibility from the patient perspective and should therefore be interpreted within the context of the national health system and service delivery model. This is particularly relevant in Uzbekistan, where several laboratory investigations and specialised clinical services have been centralised to improve quality assurance, equipment utilisation, maintenance and workforce specialisation. A clear example is the General Service Readiness diagnostic domain, which assesses the availability of six tracer point-of-care diagnostic tests (haemoglobin, blood glucose, urine protein, urine glucose, pregnancy and syphilis rapid tests) using a binary scoring system: facilities receive one point if the test can be performed on-site with functioning equipment and available reagents observed on the day of assessment, and zero if it cannot. Consequently, where blood or urine specimens are routinely referred to district or regional laboratories, the corresponding tracer diagnostic receives a score of zero, even if an efficient specimen transport system exists and results are returned promptly. The diagnostic readiness score therefore reflects the facility's capacity to provide point-of-care diagnostics rather than the overall diagnostic capacity of the health system. Accordingly, lower diagnostic readiness scores may reflect Uzbekistan's chosen service delivery model rather than deficiencies in patient access. However, where these diagnostics are expected to be available at primary health care facilities, low readiness scores identify genuine gaps in facility readiness that may warrant investment.

High levels of readiness may not equate to high quality care: The SARA methodology measures the presence and functionality of the essential inputs required to deliver health services but does not assess the quality of clinical practice or patient outcomes. While a facility may possess the equipment, medicines and trained staff necessary to provide a service, the assessment does not evaluate whether clinical guidelines are consistently followed, whether services are delivered appropriately, whether care results in improved health outcomes, whether services are cost effective, or whether patient are satisfied with services (e.g. waiting times). WHO has several additional more qualitative tools that can do this (e.g. modules #3 and #4 within the Harmonized Healthcare Facility Assessment series) but these were considered beyond the scope of this assessment – considering the time and resources available.

National representativeness: The survey was designed to produce statistically representative estimates at the national level and to enable comparisons between the five (5) primary health care facility types. Although facilities were selected from all 14 regions of Uzbekistan, the sample was not designed specifically to generate representative estimates for individual regions. Regional findings may be used but should therefore be interpreted with appropriate caution.

3. RESULTS: SERVICE AVAILABILITY & UTILIZATION

3.1 Primary health care service availability

The SARA assessment calculated the availability of primary health care services, defined as the number of primary health facilities visited that offered the service divided by the total number of facilities visited.

Primary health care service availability was generally high across Uzbekistan. Family planning (85%), antenatal care (83%), routine immunization (87%), child health (88%), diabetes (87%), cardiovascular disease (86%) and chronic respiratory disease (80%) services were available in most primary health care facilities. Prevention of mother-to-child transmission (73%) and cervical cancer screening (54%) showed more moderate coverage. In contrast, tuberculosis (18%), sexually transmitted disease (17%), HIV counselling and testing (40%), HIV care and support (21%), antiretroviral prescription and management (17%) and basic surgery (39%) were available in fewer facilities, reflecting Uzbekistan's service delivery model in which these services are intentionally concentrated within higher-level facilities.

		Pre Reform Facilities		Post Reform Facilities		
Primary Health Care Service Availability (calculated as number of facilities offering the service / total number of facilities visited)	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
A) Child health services - 90% (323/362) of facilities						
S11) Preventive and curative care for children under five	88%	91%	82%	88%	95%	71%
S11_01) Malnutrition diagnosis and treatment	80%	84%	73%	78%	89%	54%
S11_02) Vitamin A supplementation	49%	52%	45%	51%	52%	25%
S11_03) Iron supplementation	60%	57%	58%	64%	68%	42%
S11_04a) ORS for children with diarrhoea	69%	72%	63%	72%	77%	38%
S11_04b) Zinc supplementation to children with diarrhoea	27%	25%	28%	24%	36%	8%
S11_05) Child growth monitoring	75%	80%	71%	71%	88%	38%

S11_06) Treatment of pneumonia	35%	37%	45%	25%	38%	8%
S11_07) Administration of amoxicillin for treatment of pneumonia	33%	33%	36%	29%	41%	8%
B) Reproductive, maternal and newborn health - 87% (316/362) of facilities						
S7) Family planning services	85%	91%	79%	81%	90%	63%
S8) Antenatal care services	83%	88%	76%	79%	88%	75%
S20) Prevention of Mother to Child Transmission	73%	78%	77%	61%	77%	54%
C) Immunization services - 87% (316/362) of facilities						
S10) Routine immunization services	87%	97%	78%	90%	93%	46%
S10_07) Birth immunization	88%	97%	79%	90%	93%	46%
S10_08) Infant immunization	87%	96%	79%	90%	92%	46%
S10_09) Adult immunization	70%	72%	62%	85%	78%	25%
D) Communicable disease services - 54% (197/362) of facilities - mainly MCPs						
S17) HIV counselling and testing	40%	46%	71%	21%	27%	13%
S18) HIV care and support	21%	23%	50%	4%	10%	4%
S19) Antiretroviral prescription and client management	17%	13%	54%	1%	1%	4%
S21) Sexually transmitted diseases	17%	17%	42%	3%	8%	4%
S16) Tuberculosis services	18%	18%	41%	7%	10%	4%
E) Non-communicable diseases - 87% (316/362) of facilities						
S22) Diabetes	87%	86%	92%	82%	90%	75%
S23) Cardiovascular disease	86%	86%	91%	82%	90%	75%
S24) Chronic respiratory diseases	80%	82%	91%	68%	84%	63%
S29) Cervical cancer	54%	57%	73%	32%	60%	17%
F) Outpatient surgical services - 39% (142/362) of facilities - mainly MCPs						
S25) Basic surgery	39%	50%	91%	3%	14%	8%
S25_01) Incision and drainage of abscesses	30%	38%	76%	0%	8%	0%
S25_02) Wound care and dressing	19%	16%	62%	0%	5%	0%
S25_03) Management of minor burns	17%	22%	42%	0%	7%	0%
S25_04) Suturing of wounds	20%	18%	58%	0%	7%	0%

S25_05) Non-surgical treatment of fractures	10%	7%	38%	0%	0%	0%
S25_07) Male circumcision	11%	4%	42%	0%	1%	0%
S25_12) Removal of foreign bodies (throat, eye, ear or nose)	11%	9%	33%	0%	4%	0%
S25_10 Non-surgical treatment of dislocated joints	9%	5%	35%	0%	1%	0%

Table 5: Primary health care service availability by facility type

Disaggregation by facility type reveals a considerably more differentiated picture.

Type II Family Polyclinics have largely maintained, and in several areas exceeded, the availability of core services previously provided by pre-reform Family Polyclinics. Preventive and curative child health services were available in 95% of Type II facilities, compared with 91% of pre-reform Family Polyclinics. Type II facilities also reported higher availability of: malnutrition diagnosis and treatment: 89% versus 84%; iron supplementation: 68% versus 57%; oral rehydration therapy: 77% versus 72%; zinc supplementation: 36% versus 25%; child growth monitoring: 88% versus 80%; administration of amoxicillin for pneumonia: 41% versus 33%.

A similar pattern was observed for reproductive and maternal health services. Family planning was available in 90% of Type II facilities, compared with 91% of pre-reform Family Polyclinics, while antenatal care availability was identical at 88%. Prevention of mother-to-child transmission services was available in 77% of Type II facilities, compared with 78% of pre-reform Family Polyclinics.

Type II facilities also performed at or above the level of pre-reform Family Polyclinics for major non-communicable disease services: diabetes: 90% versus 86%; cardiovascular disease: 90% versus 86%; chronic respiratory disease: 84% versus 82%; cervical cancer services: 60% versus 57%.

These findings indicate that Type II Family Polyclinics are functioning effectively as the principal service hubs of the post-reform PHC model and have broadly preserved the availability of the core PHC package.

Type I Family Polyclinics showed a more mixed pattern. Availability remained relatively high for child health services (88%), routine immunisation (90%), diabetes care (82%) and cardiovascular disease services (82%). However, Type I facilities performed below pre-reform Family Polyclinics in several areas: family planning: 81% versus 91%; antenatal care: 79% versus 88%; chronic respiratory disease services: 68% versus 82%; cervical cancer services: 32% versus 57%.

Because these are core primary care functions rather than services intentionally transferred to hospitals or specialised programmes, the differences indicate incomplete and uneven implementation of the intended service package across Type I facilities.

The next phase of reform should therefore focus on standardising the core Type I service package and ensuring that all Type I facilities are able to provide the required maternal, reproductive and non-communicable disease services consistently. This requires clear service specifications, appropriate staffing and competencies, essential commodities and equipment, and systematic implementation of national clinical guidance.

The largest gaps within the post-reform network were observed in Type II Branches. Child health services were available in only 71% of branches, compared with 95% of Type II facilities. Availability of several basic child health interventions was particularly low: child growth monitoring: 38%; oral rehydration therapy:

38%; zinc supplementation: 8%; pneumonia treatment: 8%; administration of amoxicillin: 8%. Routine immunisation was available in only 46% of branches. Family planning was available in 63%, antenatal care in 75%, and cervical cancer services in 17%.

The absence of specialist or hospital-level services at branch level would be consistent with the intended network model. However, the low availability of basic child health, preventive and immunisation services cannot be explained solely by the intentional redistribution of specialist functions. These results indicate that branches have not yet been fully operationalised as reliable local first-contact points within the Type II network.

The priority should not be to replicate the full Type II service package in every branch. Rather, the reform should establish and consistently deliver a clearly defined minimum branch package, including basic preventive and curative child health services, routine immunisation, essential medicines and commodities, basic equipment, predictable operating hours, and effective referral and follow-up through the linked Type II Family Polyclinic.

Communicable disease and outpatient surgical services require a different interpretation. HIV counselling and testing was available in: 71% of MCPs; 46% of pre-reform Family Polyclinics; 21% of Type I facilities; 27% of Type II facilities; 13% of branches. Tuberculosis services were available in 41% of MCPs, compared with 7% of Type I facilities, 10% of Type II facilities and 4% of branches.

The difference was even more pronounced for basic outpatient surgery: MCPs: 91%; pre-reform Family Polyclinics: 50%; Type I: 3%; Type II: 14%; Type II Branches: 8%.

These findings should not be interpreted as evidence that the reform has reduced the availability of these services. MCPs were specialist outpatient facilities under the pre-reform model, whereas their specialist, diagnostic and surgical functions are being transferred to consultative and diagnostic departments of central hospitals under the new model.

The substantially lower availability of specialist, diagnostic and selected outpatient procedures in post-reform Family Polyclinics should be interpreted in the context of the service reconfiguration established by Presidential Decree No. UP-88 and Presidential Resolution No. PP-185. Under the new model, Multidisciplinary Central Polyclinics are transformed into consultative and diagnostic departments of central hospitals, while Family Polyclinics provide first-contact care and issue electronic referrals to narrow specialists and hospitals. Central hospitals are responsible for specialist consultations and laboratory, diagnostic, outpatient and inpatient services, and an interregional central laboratory service is established to support both hospitals and Family Polyclinics.

Accordingly, lower onsite availability of services that were previously concentrated in MCPs—particularly specialist consultations and selected diagnostic services—may reflect the intended redistribution of functions rather than incomplete implementation of the Family Polyclinic model. The relevant requirement under the reform is therefore not necessarily that every service be available onsite in each Family Polyclinic, but that patients have a functional referral pathway to the designated central hospital or specialised provider.

However, UP-88 and PP-185 do not explicitly state where tuberculosis services, HIV services or each type of minor outpatient surgery should be provided under the new model. Their lower availability in post-reform Family Polyclinics therefore cannot automatically be interpreted either as a reform failure or as an intended result of the reform. The report should state that these findings may reflect the new referral-based model, while avoiding a definitive conclusion unless the service is clearly assigned to another level of care by the approved service package or relevant programme regulations.

The service-availability findings show that the post-reform model is developing unevenly.

Type II Family Polyclinics have broadly maintained or improved the availability of the principal PHC services delivered under the previous Family Polyclinic model. Type I facilities provide most core services but show important gaps in reproductive, maternal, chronic respiratory and cervical cancer services. Type II Branches remain the least operationally developed component of the new network, including for several basic services that should be available close to the community.

The next phase of reform should therefore prioritise two areas:

- completing and standardising implementation of the core service package in Type I facilities and Type II Branches; and
- ensuring that services intentionally transferred from MCPs are accessible through functional referral, feedback and continuity-of-care arrangements between Family Polyclinics and central hospitals.

This distinction is critical: low availability of core first-contact services represents an implementation gap, whereas low availability of specialist and surgical services may represent the intended redesign of the service-delivery model.

3.2 Service utilization

3.2.1 Average number of outpatient visits per facility in 2025

- ☐ Findings show facility workload varied substantially by facility type, reflecting their different roles within Uzbekistan's primary health care system. Multidisciplinary Central Polyclinics recorded the highest average outpatient workload (400,767 visits annually), approximately five times that of Family Polyclinics and fourteen times that of Type I Family Polyclinics. On average each family polyclinic had 75,042 outpatient visits in 2025.
- ☐ On average each MCP had 400,767 outpatient visits in 2025.
- ☐ On average each family polyclinic (type I) had 28,405 outpatient visits in 2025.
- ☐ On average each family polyclinic (type II) had 78,676 outpatient visits in 2025.
- ☐ On average each family polyclinic (type II branch) had 3,620 visits in 2025.

Facility Type	Average Number of Outpatient Visits (2025)
Family Polyclinic (n=115)	75,042
Multidisciplinary Central Polyclinic (n=78)	400,767
Family Polyclinic Type 1 (n=72)	28,405
Family Polyclinic Type 2 (n=73)	78,676
Family Polyclinic Type 2 Branch (n=24)	3,620

Table 6: Average number of outpatient visits per facility per year

Average annual outpatient volumes varied substantially by facility type, reflecting major differences in institutional scale and function. Multidisciplinary Central Polyclinics recorded the highest average volume, with 400,767 visits per facility. This reflects their pre-reform role as district- or city-level specialist outpatient and diagnostic centres receiving referrals from multiple first-contact facilities. Their visit volumes are therefore not directly comparable with those of Family Polyclinics or post-reform facilities.

Among first-contact facilities, post-reform Type II Family Polyclinics recorded an average of 78,676 visits per facility, broadly comparable with the 75,042 visits recorded by pre-reform Family Polyclinics. This indicates that Type II facilities have assumed a service volume similar to that of the previous Family Polyclinic model and are functioning as the main service hubs within the post-reform network.

Type I Family Polyclinics recorded a lower average volume of 28,405 visits per facility, while Type II Branches recorded 3,620 visits. These lower absolute volumes are consistent with the smaller scale and more localised role of these facilities within the new model. They should not be interpreted as evidence of lower service utilisation or weaker performance because this indicator does not account for differences in attached population.

Overall, the findings show a differentiated post-reform service-delivery structure: Type II Family Polyclinics operate at a volume comparable with pre-reform Family Polyclinics, while Type I facilities and branches provide lower-volume services in accordance with their smaller scale and position within the Type II network. The average number of visits per facility is therefore best interpreted as an indicator of facility workload rather than population service utilisation.



Figure 6. Family Polyclinic Type II Branch, Denov District, Surkhandarya



Figure 7. Family Polyclinic #1 Tashkent City

3.2.2 Primary health care service utilization

Annual outpatient visits per capita measure the average number of PHC visits made per person during the year. The results indicate that utilisation has been broadly maintained in the two principal post-reform facility types. Pre-reform Family Polyclinics recorded an average of 3.7 outpatient visits per person in 2025, compared with 3.5 visits in Type I Family Polyclinics and 3.9 visits in Type II Family Polyclinics. The close similarity between these figures suggests that the transition to the new model has not reduced the overall use of first-contact PHC services. Type II facilities recorded the highest utilisation among first-contact facilities, consistent with their role as the principal service hubs within the post-reform network.

Multidisciplinary Central Polyclinics recorded 2.9 visits per person. This figure should be interpreted separately because MCPs operated as specialist outpatient referral facilities under the pre-reform model rather than as directly comparable first-contact facilities serving an attached population through family medicine.

- ☐ Family Polyclinic: Average of 3.7 visits per person per year in 2025.
- ☐ Multidisciplinary Central Polyclinic: Average of 2.9 visits per person per year.
- ☐ Family Polyclinic Type 1: Average of 3.5 visits per person per year in 2025.
- ☐ Family Polyclinic Type 2: Average of 3.9 visits per person per year in 2025.
- ☐ Family Polyclinic Type 2 Branch: Average of 2.0 visits per person per year.

Facility Type	Average Number of Visits Per Person Per Year (2025)
Family Polyclinic (n=115)	3.7
Multidisciplinary Central Polyclinic (n=78)	2.9
Family Polyclinic Type 1 (n=72)	3.5
Family Polyclinic Type 2 (n=73)	3.9
Family Polyclinic Type 2 Branch (n=24)	2.0
Average (n=362)	**3.4**

Table 7: Average number of outpatient visits per capita per year

The principal utilisation gap within the post-reform model is observed in Type II Branches, which recorded only 2.0 visits per person per year. This was substantially below pre-reform Family Polyclinics and post-reform Type I and Type II facilities. Some difference may be expected because branches provide a more limited onsite service package and rely on linked Type II Family Polyclinics for additional services. However, the magnitude of the gap, together with the substantially lower service availability and readiness recorded in branches, indicates that intentional differentiation of functions does not fully explain their lower utilisation. Branches are not yet operating as consistently effective local access points across the post-reform network.

The next phase of reform should therefore focus on completing the operationalisation of Type II Branches. Priority should be given to ensuring a clearly defined and consistently available minimum service package, reliable operating hours, essential equipment and commodities, and effective referral and follow-up arrangements with the linked Type II Family Polyclinic. The objective should not be to replicate the full Type II service package in every branch, but to ensure that each branch provides dependable first-contact care and functions as an integral part of the Type II service network.

Overall, the findings show that utilisation has been maintained in Type I and Type II Family Polyclinics. The key remaining issue is the marked utilisation gap in Type II Branches, which points to incomplete operationalisation of this component of the post-reform model.

3.2.3 Average number of patients each doctor sees per day

Daily doctor workload was highly consistent across pre-reform Family Polyclinics and the two principal post-reform facility types. Doctors in pre-reform Family Polyclinics saw an average of 29.6 outpatients per day, compared with 30.6 in Type I Family Polyclinics and 29.2 in Type II Family Polyclinics. These findings indicate that the reform has broadly maintained doctor workload in the main first-contact PHC facilities, with no evidence of a substantial shift in workload between the previous and new models.

Multidisciplinary Central Polyclinics recorded a similar average of 28.2 outpatients per doctor per day. However, MCPs operated as specialist outpatient referral facilities under the pre-reform model and should therefore be interpreted separately rather than used as a direct benchmark for first-contact Family Polyclinics.

Type II Branches recorded a substantially lower workload of 18.3 outpatients per doctor per day, approximately 38% below the level observed in pre-reform Family Polyclinics and post-reform Type I and Type II facilities. Some difference is consistent with the intended role of branches as small local access points serving populations of up to 3,000 people and operating for shorter hours, with 75% open for 5–8 hours per day.

- ☐ Family Polyclinics: 29.6 outpatients per day.
- ☐ Multidisciplinary Central Polyclinics: 28.2 outpatients per day.
- ☐ Family Polyclinic Type I: 30.6 outpatients per day.
- ☐ Family Polyclinic Type II: 29.2 outpatients per day.
- ☐ Family Polyclinic Type II Branch: 18.3 outpatients per day.

Facility Type	**Average number of patients each doctor sees per day.**
Family Polyclinic (n=115)	29.6
Multidisciplinary Central Polyclinic (n=78)	28.2
Family Polyclinic Type 1 (n=72)	30.6
Family Polyclinic Type 2 (n=73)	29.2
Family Polyclinic Type 2 Branch (n=24)	18.3
Average (n=362)	**28.7**

Table 8: Average number of reported outpatient consultations per doctor per working day by facility type

This indicator alone does not establish that the lower branch workload represents a performance problem rather than an intended feature of the network design. However, when considered alongside the lower per capita utilisation, service availability and readiness observed in branches, it reinforces the finding that this component of the post-reform model is not yet operating as consistently as Type I and Type II Family Polyclinics.

The priority should therefore be to ensure that branches provide a reliable minimum package of first-contact services during predictable operating hours and are effectively linked to their parent Type II Family Polyclinic for referral, follow-up and services not available onsite. The objective is not to equalise doctor workload across facility types, but to ensure that lower workload at branch level reflects an appropriate division of functions rather than limited operational capacity or service use.

Overall, the findings show that doctor workload has been maintained in Type I and Type II Family Polyclinics. The lower workload in branches is consistent with their smaller role but, in the context of the wider SARA findings, also points to the need to strengthen their functioning within the Type II network.

Daily operating hours by facility type

Findings show most primary health care facilities provide extended opening hours: Overall, 71% of facilities operated for 9–16 hours per day, providing patients with access beyond a standard working day. Extended opening hours were common in Family Polyclinics, Multidisciplinary Central Polyclinics and Type II Family Polyclinics, whereas Type I Family Polyclinics and Branch facilities were more likely to operate for 5–8 hours per day, reflecting their more limited role within the primary health care network.

- ☐ On average 0.5% (1/362) of facilities are open for 4 hours or less a day.
- ☐ On average 28% (102/362) of facilities are open for 5 to 8 hours a day.
- ☐ On average 71% (258/362) of facilities are open for 9 to 16 hours a day.
- ☐ On average 0.5% (1/362) of facilities are open for 17 to 23 hours a day.

Facility Type	4 hours or less	%	5 to 8 hours	%	9 to 16 hours	%	17 to 23 hours	%
Family Polyclinic (n=115)	0	0%	16	14%	99	86%	0	0%
Multidisciplinary Central Polyclinic (n=78)	0	0%	11	14%	66	85%	1	1%
Family Polyclinic Type 1 (n=72)	0	0%	43	60%	29	40%	0	0%
Family Polyclinic Type 2 (n=73)	0	0%	14	19%	59	81%	0	0%
Family Polyclinic Type 2 Branch (n=24)	1	4%	18	75%	5	21%	0	0%
Grand Total (n=362)	**1**	**0%**	**102**	**28%**	**258**	**71%**	**1**	**0%**

Table 9: Distribution of surveyed facilities by reported daily operating hours and facility type

Reported daily operating hours differed markedly across facility types, reflecting the differentiated organisation of services under the pre-reform and post-reform PHC models. Overall, 258 of 362 facilities (71.3%) operated for 9–16 hours per day, while 102 facilities (28.2%) operated for 5–8 hours. One facility operated for four hours or less, and one operated for 17–23 hours.

The comparison between pre-reform Family Polyclinics and post-reform Type II Family Polyclinics indicates that extended-hours service capacity has largely been maintained. Eighty-one per cent of Type II facilities operated for 9–16 hours per day, compared with 86% of pre-reform Family Polyclinics. This supports the role of Type II Family Polyclinics as the principal service hubs within the new PHC network.

Type I Family Polyclinics and Type II Branches followed a different operating pattern. Sixty per cent of Type I facilities and 75% of branches operated for 5–8 hours per day, while only 40% and 21%, respectively, operated for 9–16 hours. This is consistent with the post-reform model, under which Type II facilities provide extended-hours coverage for the populations served by linked Type I facilities and branches rather than requiring every facility in the network to remain open for the same number of hours.

The shorter operating hours of Type I facilities and branches should therefore not automatically be classified as an access gap. This indicator demonstrates a redistribution of extended-hours capacity within the network, but it does not show whether patients can use the linked Type II facility conveniently after their local facility closes.

The reform priority is consequently not to extend the opening hours of every Type I facility and branch to match Type II facilities. Rather, each network should have clearly defined and operational extended-hours arrangements, with predictable opening schedules, clear information for patients, and effective access from linked Type I facilities and branches to the Type II service hub.

Overall, the findings indicate that extended-hours capacity has been preserved in Type II Family Polyclinics, while Type I facilities and branches operate mainly as shorter-hours local access points. This pattern is consistent with the intended differentiation of functions within the post-reform PHC network.

3.2.4 Human resources composition by facility type

Findings show the primary health care workforce is aligned with the role of each facility type: Workforce composition increased progressively with facility size and complexity. Multidisciplinary Central Polyclinics had the largest workforce, particularly specialist doctors, nursing professionals and laboratory technicians, reflecting their role as referral centres providing a broader range of services. Family Polyclinics and Type II Family Polyclinics had intermediate staffing levels, while Type I and Branch facilities operated with smaller multidisciplinary teams serving local communities. Across all facility types, nursing professionals formed the largest professional group, highlighting their central role in primary health care delivery. Laboratory capacity is concentrated in larger facilities. Specialist services are concentrated in Multidisciplinary Central Polyclinics.

Facility Type	Average number of generalist (non-specialist) medical doctors:	Average number of specialist medical doctors:	Average number nursing professionals:	Average number laboratory technicians (medical and pathology):
Family Polyclinic (n=115)	6.7	6.3	52.8	2.0
Multidisciplinary Central Polyclinic (n=78)	16.8	47.3	173.7	8.8
Family Polyclinic Type 1 (n=72)	2.5	1.3	18.4	1.1
Family Polyclinic Type 2 (n=73)	6.3	5.3	45.1	1.2
Family Polyclinic Type 2 Branch (n=24)	0.9	0.3	2.8	0.1
Average (n=362)	**7.6**	**14.1**	**67.3**	**3.0**

Table 10: Average numbers of specialists, generalists, nurses and technicians, by facility type

Average workforce composition varied substantially by facility type, reflecting differences in institutional scale and function within the pre-reform and post-reform service-delivery models. The figures show average staff numbers per facility and should therefore be interpreted as workforce composition rather than workforce density or staffing adequacy.

Multidisciplinary Central Polyclinics had by far the largest workforce, averaging 16.8 generalist doctors, 47.3 specialist doctors, 173.7 nursing professionals and 8.8 laboratory technicians. This reflects their pre-reform role as district- or city-level specialist outpatient, diagnostic and referral centres serving patients referred from multiple first-contact facilities. Their staffing profile is therefore not an appropriate benchmark for post-reform Family Polyclinics. Under the reform, many of these specialist and diagnostic functions are being transferred to consultative and diagnostic departments of central hospitals rather than reproduced within each Type I or Type II Family Polyclinic.

The most relevant comparison is between pre-reform Family Polyclinics and post-reform Type II Family Polyclinics. Type II facilities had a broadly similar medical workforce, with an average of 6.3 generalist doctors and 5.3 specialist doctors, compared with 6.7 and 6.3, respectively, in pre-reform Family Polyclinics. Type II facilities had fewer nursing professionals—45.1 compared with 52.8—and fewer laboratory technicians—1.2 compared with 2.0. The lower number of laboratory staff is consistent with the reform's centralisation of selected diagnostic functions. The smaller nursing workforce should not, on the basis of absolute staff numbers alone, be interpreted as a staffing deficit, particularly as Type II facilities maintained service volumes and doctor workloads broadly comparable with pre-reform Family Polyclinics.

Type I Family Polyclinics operated with smaller teams, averaging 2.5 generalist doctors, 1.3 specialist doctors, 18.4 nursing professionals and 1.1 laboratory technicians. This is consistent with their smaller catchment populations and more limited role within the post-reform network. Their lower absolute staffing levels therefore appear to reflect intentional differentiation between Type I and Type II facilities rather than a loss of workforce capacity.

Type II Branches had the smallest teams, averaging 0.9 generalist doctors, 0.3 specialist doctors, 2.8 nursing professionals and 0.1 laboratory technicians. The very limited presence of specialists and laboratory technicians is consistent with the branch model, under which these services are accessed through the linked Type II Family Polyclinic or the wider referral network. However, the average of fewer than one generalist doctor per branch points to a potential gap in routine medical coverage at the local first-contact level. This is particularly relevant because branches are intended to provide accessible PHC services to remote communities.

The priority for the next phase of reform should therefore be to ensure a clear minimum staffing arrangement for every Type II Branch, including predictable access to a generalist doctor and adequate nursing coverage. Where doctors are shared or deployed from the linked Type II facility, this should operate according to a defined schedule that guarantees continuity of first-contact care. Specialist and laboratory staff do not need to be replicated in each branch, but access to these services through the Type II facility and the referral network must be organised as part of the branch service model.

Overall, the workforce findings indicate that Type II Family Polyclinics have largely retained the medical staffing profile of pre-reform Family Polyclinics, while Type I facilities and branches operate with progressively smaller teams in line with their differentiated roles. The clearest workforce issue within the post-reform model is not the lower number of specialists or laboratory technicians in smaller facilities, which largely reflects intentional service reconfiguration, but the limited generalist medical presence at branch level.

3.2.5 Human resources staffing levels

Findings show that doctor recruitment remains the principal workforce challenge: Overall, 86% of doctor positions were filled across the primary health care network, compared with almost complete staffing of nursing (99%) and non-medical (99%) posts. Doctor vacancy rates were relatively consistent across all facility types, suggesting that medical workforce shortages represent a system-wide challenge rather than one affecting particular facilities. In contrast, the consistently high occupancy of nursing and support posts demonstrates a stable health workforce capable of supporting primary health care service delivery.

- ☐ On average 86.1% of doctor staffing positions were filled.
- ☐ On average 98.9% of nurse staffing positions were filled.
- ☐ On average 99.4% of non-medical staffing positions were filled.

Facility Type	Average doctors staffing level (% filled)	Average nurses staffing level (% filled)	Average non-medical staff staffing level (% filled)
Family Polyclinic (n=115)	84.9	97.7	98.8
Multidisciplinary Central Polyclinic (n=78)	86.9	98.3	99.3
Family Polyclinic Type 1 (n=72)	88.1	99.9	99.7
Family Polyclinic Type 2 (n=73)	86.2	99.9	100.0
Family Polyclinic Type 2 Branch (n=24)	83.3	100.0	100.0
Average (n=362)	**86.1**	**98.9**	**99.4**

Table 11: Mean percentage of approved staff positions filled, by staff category and facility type

Doctor vacancies represent the main staffing gap across the PHC network. On average, 86.1% of approved doctor positions were filled, compared with 98.9% of nursing positions and 99.4% of non-medical positions. The data therefore point to incomplete filling of medical posts rather than a general shortage across all workforce categories.

Comparison of pre-reform and post-reform facilities shows that the reform has not reduced doctor-post occupancy in the two principal new facility types. Pre-reform Family Polyclinics had 84.9% of approved doctor positions filled, compared with 88.1% in Type I Family Polyclinics and 86.2% in Type II Family Polyclinics. Doctor staffing in Type I and Type II facilities is therefore at least comparable with the previous Family Polyclinic model.

Type II Branches recorded the lowest doctor-post occupancy, at 83.3%. The difference from other facility types is modest in percentage terms, but its operational significance is greater because branches have very small medical teams, averaging fewer than one generalist doctor per facility. A vacancy at branch level may therefore result in limited or intermittent access to a doctor rather than simply a small reduction in overall staffing.

Nursing and non-medical posts were almost fully occupied across all post-reform facility types, reaching 99.9–100% in Type I, Type II and branch facilities. This is a relative strength of the new model. However, the indicator measures the proportion of approved posts filled and does not demonstrate that the approved staffing establishment is sufficient for the intended service package, attached population or workload.

The findings therefore indicate two distinct workforce conclusions for the post-reform model. First, Type I and Type II Family Polyclinics have maintained doctor-post occupancy at or above the level of pre-reform Family Polyclinics. Second, Type II Branches remain the most vulnerable component of the network because lower doctor-post occupancy is combined with an already very small medical workforce.

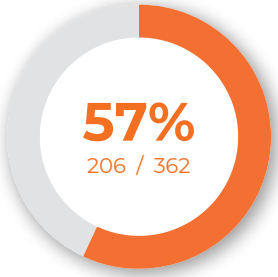
The next phase of reform should prioritise reliable medical coverage at branch level. This does not necessarily require a separate full-time doctor in every branch if the approved model provides for shared staffing, but it does require a clearly defined and predictable arrangement through the linked Type II Family Polyclinic, ensuring that the branch population has regular access to a doctor and uninterrupted first-contact care.

Overall, the main workforce challenge is not deterioration in staffing following the reform, but the remaining gap in filling doctor positions, particularly in Type II Branches. Near-complete occupancy of nursing and non-medical posts provides a strong operational base, while medical coverage at branch level requires targeted attention.

4. RESULTS: GENERAL SERVICE READINESS

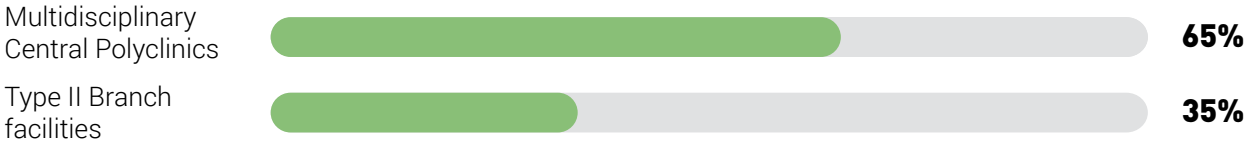
Key Findings

National General Service Readiness (GSR) score





Readiness



Basic amenities scores should be examined further. One in ten facilities had no internet at the time of the visit, one in ten had no water at the time of the visit, half the facilities had no dedicated toilets for staff, one third relied on pit latrines, and only 1 in 5 had a backup generator.

Future investment should consider investigation access to essential onsite diagnostics and essential medicines while sustaining the high levels of infrastructure, equipment and infection prevention. All the GSR indicators are essential for quality PHC and future investment should consider aiming to reach 100% GSR coverage.

In addition to measuring the availability of individual health services, the SARA tool calculates a General Service Readiness (GSR) Score to provide an overall measure of whether primary health care facilities possess the minimum resources (basic amenities, basic equipment, requirements for infection prevention and control, diagnostic capacity, essential medicines) required to deliver safe and effective health services. The GSR is applied to all facilities regardless of the services provided or the level of primary health care.

It is calculated by taking the average of the five main domains as follows:
Formula:

$$\textbf{GSR (\%)} = \frac{DO1+DO2+DO3+DO4+DO5}{5}$$

where:
D01 = Basic amenities domain score (77%)
D02 = Basic equipment domain score (92%)
D03 = Standard precautions for infection prevention and control domain score (78%)
D04 = Onsite diagnostic capacity domain score (13%)
D05 = Essential medicines domain score (27%)

$$\textbf{GSR (\%)} = \frac{77\%+92\%+78\%+13\%+27\%}{5} = 57\%$$

The 2026 SARA assessment yielded a General Service Readiness score of 57%, indicating that while primary health care facilities possess many of the basic requirements needed to deliver essential services, important gaps remain. This aggregate provides a general snapshot of PHC readiness during the transition period, but it combines facilities operating under two different organisational models. Progress in reform implementation is therefore better understood through comparison of pre-reform and post-reform facility types.

		Pre Reform Facilities		Post Reform Facilities		
GSR) National Level General Service Readiness Score Calculated as mean of items GSR = (D01 + DO2 + DO3 + DO4 + DO5) / 5	57%	59%	65%	54%	57%	35%
Domain and Indicator Readiness Scores	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
DO1) Basic amenities Calculated as mean of items D01 = (I1 + I2 + I3 + I4 + I5 + I6 + I7) / 7	**77%**	**81%**	**85%**	**73%**	**76%**	**47%**

I1) Power: Facility routinely has electricity for lights and communication (at a minimum) from any power source during normal working hours; there has not been a break in power for more than 2 hours per day during the past 7 days.	83%	89%	97%	69%	78%	67%
I2) Improved water source inside OR within the ground of the facility	95%	99%	100%	94%	96%	58%
I3) Room with auditory and visual privacy for patient consultations	37%	40%	56%	19%	37%	13%
I4) Access to adequate sanitation facilities for clients	94%	99%	99%	93%	93%	54%
I5) Communication equipment	97%	98%	100%	100%	97%	67%
I6) Facility has access to computer with email/internet access	90%	93%	94%	96%	89%	54%
I7) Emergency transportation	42%	48%	46%	38%	40%	17%
DO2) Basic equipment Mean of tracer items E01 = (E1 + E2 + E3 + E4 + E5 + E6) / 6	**92%**	**97%**	**94%**	**91%**	**93%**	**71%**
E1) Adult scale	94%	98%	96%	90%	97%	67%
E2) Child scale	84%	94%	85%	82%	82%	50%
E3) Thermometer	96%	98%	95%	97%	96%	92%
E4) Stethoscope	86%	95%	92%	82%	88%	38%
E5) Blood pressure apparatus	94%	96%	94%	94%	95%	79%
E6) Light source	100%	100%	100%	100%	100%	100%
DO3) Standard precautions for infection prevention Domain score = Mean score of items as percentage i.e N/9*100	78%	82%	88%	71%	79%	45%
I9) Safe final disposal of sharps	85%	81%	94%	82%	86%	75%
I10) Safe final disposal of infectious wastes	53%	59%	86%	35%	44%	4%
I11) Appropriate storage of sharps waste	87%	87%	95%	86%	95%	38%
I12) Appropriate storage of infectious waste	67%	80%	94%	47%	53%	17%
I13) Disinfectant	85%	88%	85%	81%	90%	63%
I14) Single use —standard disposable or auto-disable syringes	74%	81%	74%	68%	79%	38%

I15) Soap and running water or alcohol based hand rub	94%	95%	95%	90%	99%	79%
I16) Latex gloves	86%	90%	90%	83%	89%	46%
I17) Guidelines for standard precautions	76%	80%	85%	69%	78%	46%
DO4) Diagnostic capacity (onsite) Domain score = Mean score of items as percentage i.e N/6*100	13%	11%	28%	6%	9%	1%
D1) Haemoglobin	12%	16%	28%	0%	4%	0%
D2) Blood glucose	35%	33%	50%	31%	36%	4%
D3) Urine dipstick- protein	9%	8%	24%	1%	5%	0%
D4) Urine dipstick- glucose	10%	10%	24%	1%	5%	0%
D9) Syphilis rapid test	9%	0%	37%	0%	3%	0%
D11) Urine test for pregnancy	2%	0%	6%	0%	3%	4%
DO5) Essential medicines Domain score = Mean score of items as percentage i.e N/25*100	27%	26%	31%	28%	30%	11%
M56) Amlodipine tablet or alternative calcium channel blocker	37%	32%	32%	47%	47%	17%
M33) Amoxicillin syrup/suspension or dispersible tablet	41%	42%	35%	39%	58%	13%
M2) Amoxicillin tablet	45%	48%	51%	36%	53%	13%
M71) Ampicillin powder for injection	27%	30%	27%	21%	36%	4%
M57) Aspirin cap/tab	47%	48%	42%	53%	55%	17%
M59) Beclomethasone inhaler	15%	13%	23%	13%	18%	0%
M55) Beta blocker (e.g. bisoprolol, metoprolol, carvedilol, atenolol)	44%	41%	44%	56%	47%	25%
M119) Carbamazepine tablet	13%	1%	53%	7%	0%	0%
M5) Ceftriaxone injection	17%	21%	32%	6%	11%	0%
M25) Diazepam injection	1%	0%	4%	0%	1%	0%
M53) Enalapril tablet or alternative ACE inhibitor e.g. lisinopril, ramipril, perindopril	38%	38%	36%	42%	41%	17%
M94) Fluoxetine tablet	1%	0%	3%	0%	0%	0%
M72) Gentamicin injection	2%	2%	4%	0%	4%	0%
M10) Glipalamide tablet	2%	2%	4%	0%	4%	0%

M124) Haloperidol tablet	4%	5%	6%	4%	1%	0%
M51) Insulin regular injection	30%	22%	81%	17%	12%	4%
M24) Magnesium sulphate injectable	69%	66%	68%	72%	84%	33%
M50) Metformin tablet	41%	34%	40%	61%	40%	25%
M11) Omeprazole tablet or alternative such as pantoprazole, rabeprazole	51%	47%	51%	61%	53%	33%
M32) Oral rehydration solution	53%	60%	46%	50%	67%	13%
M22) Oxytocin injection	4%	4%	5%	3%	4%	0%
M13) Salbutamol inhaler	53%	49%	49%	61%	59%	42%
M14) Simvastatin tablet or other statin e.g. atorvastatin, pravastatin, fluvastatin	18%	13%	19%	22%	26%	4%
M54) Thiazide (e.g. hydrochlorothiazide)	20%	17%	22%	25%	21%	4%
M36) Zinc sulphate tablets, dispersible tablets or syrup	6%	4%	5%	6%	12%	0%

Table 12: General Service Readiness (GSR) scores by facility type

Multidisciplinary Central Polyclinics recorded the highest GSR score, at 65%. This reflects their pre-reform role as large district- or city-level specialist outpatient, diagnostic and referral facilities and should not be used as the principal benchmark for post-reform first-contact facilities. The more relevant comparison is between pre-reform Family Polyclinics, which scored 59%, and the new facility types. Type II Family Polyclinics achieved a broadly comparable score of 57%, indicating that the principal service hubs of the post-reform model have largely maintained overall readiness. Type I Family Polyclinics scored 54%, showing moderately lower but broadly comparable readiness. In contrast, Type II Branches recorded a substantially lower score of 35%, identifying them as the least operationally developed component of the new PHC network.

Basic equipment was the strongest readiness domain, with a national score of 92%. Type II Family Polyclinics scored 93% and Type I facilities 91%, compared with 97% in pre-reform Family Polyclinics. Nearly all surveyed facilities had functioning light sources (100%), thermometers (96%), blood pressure apparatus (94%) and adult weighing scales (94%). These results indicate that essential clinical equipment has largely been maintained in the two principal post-reform facility types. However, equipment readiness in Type II Branches was considerably lower, at 71%. Only 67% of branches had an adult scale, 50% had a child scale and 38% had a stethoscope. As these are basic requirements for routine first-contact care, their absence represents a clear operational gap rather than an intended redistribution of functions.

Basic amenities achieved a national readiness score of 77%. Type II Family Polyclinics scored 76% and Type I facilities 73%, compared with 81% in pre-reform Family Polyclinics. This indicates that the main post-reform facilities have broadly retained the infrastructure required for routine service delivery, although readiness remains incomplete. The situation was substantially weaker in Type II Branches, which scored only 47%. Among branches, 58% had an improved water source, 54% had adequate sanitation, 54% had access to an internet-connected computer, 17% had emergency transport and only 13% had a consultation room ensuring both auditory and visual privacy. These are fundamental operating conditions for local first-contact care and demonstrate that many branches have not yet been fully operationalised.

Standard precautions for infection prevention and control achieved a national score of 78%. Type II Family Polyclinics scored 79%, close to the 82% recorded in pre-reform Family Polyclinics, while Type I facilities scored 71%. Soap and running water or alcohol-based hand rub (94%), gloves (86%), disinfectants (85%) and safe sharps disposal (85%) were widely available nationally. However, important weaknesses remained in infectious-waste management: only 53% of facilities demonstrated safe final disposal and 67% appropriate storage. These gaps were particularly severe in Type II Branches, where IPC readiness was only 45%. Safe final disposal of infectious waste was observed in 4% of branches, appropriate infectious-waste storage in 17%, appropriate sharps storage in 38%, disposable syringes in 38%, gloves in 46% and standard precaution guidelines in 46%. These findings represent a clear patient and health-worker safety concern and require standardised waste-management arrangements and reliable provision of essential IPC supplies at branch level.

Onsite diagnostic capacity was the weakest GSR domain, with a national score of 13%. Blood glucose testing was available in 35% of facilities , while haemoglobin testing (12%), urine protein testing (9%), urine glucose testing (10%), syphilis rapid testing (9%) and pregnancy testing (2%) were rarely available onsite. MCPs scored 28%, compared with 11% in pre-reform Family Polyclinics, 6% in Type I facilities, 9% in Type II facilities and 1% in branches.

These results should not be interpreted in the same way as deficiencies in water, equipment or IPC. SARA awards a diagnostic score only when a test can be performed onsite with functioning equipment and available reagents. Under the reform, selected laboratory functions are intentionally being centralised and may be accessed through referral of patients or specimens. Consequently, low onsite diagnostic scores may partly reflect the redesigned service-delivery model rather than a loss of diagnostic capacity across the health system. The reform priority should therefore be to define clearly which rapid tests must remain available onsite at Type I, Type II and branch level and which should be delivered through the centralised laboratory network, with reliable specimen transport, timely return of results and clinical follow-up.

Essential medicines readiness was also low, at 27% nationally. Type II Family Polyclinics scored 30% and Type I facilities 28%, compared with 26% in pre-reform Family Polyclinics. This suggests that medicine availability has not deteriorated in the principal post-reform facilities and is marginally higher than under the previous Family Polyclinic model. Nevertheless, the absolute level remains insufficient for consistent delivery of the intended PHC package.

Availability was relatively higher for magnesium sulphate (69%), oral rehydration solution (53%), salbutamol inhalers (53%), omeprazole (51%) and aspirin (47%), but many other essential medicines were rarely observed. The most pronounced gap was again seen in Type II Branches, where medicines readiness was only 11%. Only 13% of branches had amoxicillin syrup or dispersible tablets, 13% had oral rehydration solution and none had zinc. Unlike selected laboratory or specialist functions, medicines required for services assigned to branch level must be available where those services are delivered. Procurement and distribution should therefore be aligned with the approved service package for each facility type, with priority given to uninterrupted availability of essential child-health, maternal-health, respiratory and non-communicable disease medicines in branches.

Overall, the GSR findings indicate that Type II Family Polyclinics have broadly maintained the readiness level of pre-reform Family Polyclinics. Type I facilities also retain strong basic equipment and broadly comparable medicine availability, although they show more pronounced gaps in amenities and IPC. The clearest implementation problem is concentrated in Type II Branches. Their low overall readiness is driven not only by limited onsite diagnostics, which may partly reflect intended centralisation, but

also by deficiencies in water, sanitation, privacy, emergency referral, basic examination equipment, infection prevention and essential medicines. These are core requirements for any functioning first-contact facility and indicate incomplete operationalisation of the branch model.

The next phase of reform should therefore prioritise completing the basic operationalisation of Type II Branches, strengthening amenities and IPC in Type I facilities, establishing a facility-specific package of required point-of-care diagnostics within the centralised laboratory model, and ensuring that medicines, equipment and supplies are distributed according to the approved functions of each facility type. The objective should not be identical GSR scores or identical resources across all facilities. It should be full availability of the inputs required for each facility to deliver its assigned service package safely and effectively within the post-reform network.

4.1 Basic amenities (DO1)

Basic amenities provide the essential infrastructure required to deliver safe, effective and accessible primary health care services. These core facility resources - including reliable electricity, safe water, sanitation, consultation privacy, communication systems, internet connectivity and emergency referral transportation - enable health care workers to provide quality care, ensure infection prevention practices, maintain patient dignity, support clinical decision-making and ensure continuity of services. High availability of basic amenities is therefore a key indicator of facility readiness to deliver quality health services.

The DO1 Basic Amenities domain assesses the availability of seven tracer indicators representing the minimum infrastructure required to support routine service delivery in all health facilities regardless of services delivered. The DO1 percentage score is calculated by dividing the number of tracer indicators present on the day of the visit by 7.

Formula:

$$\textbf{DO1} = \frac{I1+I2+I3+I4+I5+I6+I7}{7} * 100\%$$

where:
I1 = Power Continuity
I2 = Improved Water
I3 = Consultation Room Privacy
I4 = Sanitation
I5 = Communication
I6 = Internet
I7 = Referral Ambulance

4.1.1 Power continuity (I1)

Reliable energy systems are essential for safe and continuous primary health care service delivery. Reliable electricity supplies are critical for lighting, cold chain systems, laboratory services, sterilization equipment, communications, digital health platforms, and life-saving medical equipment. The importance of resilient energy infrastructure in Uzbekistan has increased significantly in recent years with the rapid digitalization

of the health care system and the nationwide implementation of the DMED electronic health information system. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



The facility routinely has electricity for lights and communication (at a minimum) from any power source during normal working hours and there has not been a break in power for more than 2 hours per day during the past 7 days.

4.1.1.1 Frequency of electrical power cuts

The SARA survey asked the question "during the past 7 days, was electricity available at all times from the main or any backup source when the facility was open for services?".

- ☐ 58% (210/362) of facilities experienced no interruptions to electrical supply.
- ☐ 25% (91/362) of facilities experienced interruptions of less than 2 hours per day.
- ☐ 17% (61/362) experienced frequent interruptions of more than 2 hours per day.

The assessment found that electricity supply was generally reliable, with 58% of facilities reporting uninterrupted electricity during opening hours over the previous seven days. However, 42% experienced at least one power interruption, including 17% with frequent or prolonged interruptions (>2 hours/day). Multidisciplinary Central Polyclinics (MCPs) had the most reliable electricity supply, with 74% reporting uninterrupted power and only 3% experiencing frequent interruptions, suggesting that higher-level facilities generally benefit from more robust electrical infrastructure. Family Polyclinics also demonstrated relatively good reliability, with 68% reporting uninterrupted electricity and only 11% experiencing prolonged interruptions. Reform-model facilities experienced substantially poorer electricity reliability. Only 46% of Family Polyclinic Type 1 and 44% of Type 2 facilities reported uninterrupted electricity, while 31% of Type 1 and 22% of Type 2 experienced frequent interruptions exceeding two hours per day. Family Polyclinic Type 2 Branches experienced the least reliable electricity supply, with only 38% reporting uninterrupted electricity and 33% reporting prolonged interruptions.

Unlike the lower availability of some diagnostic or specialist services, this difference cannot be explained by an intentional redistribution of functions. Reliable electricity is a basic requirement for every facility, regardless of its size or position within the network.

The results therefore identify electrical resilience as a clear implementation gap in the post-reform model. The situation is particularly concerning in Type II facilities, which serve as the principal service hubs and generally operate for extended hours, and in branches, which are intended to provide accessible first-contact care to remote communities. Recurrent interruptions may disrupt lighting, communication systems, digital health functions, refrigeration, basic diagnostic equipment and continuity of clinical services.

The next phase of reform should prioritise reliable electricity in post-reform facilities, beginning with branches and Type I facilities experiencing prolonged interruptions, while also ensuring resilience in Type II service hubs. Measures should include correction of facility-level electrical infrastructure problems, appropriately sized backup power systems, and sustainable arrangements for maintenance and fuel or alternative energy supply. The objective should be continuous electricity during all operating hours across every post-reform facility.

	Always available (no interruptions)		Often available (interruptions of less than 2 hours per day)		Sometimes available (frequent or prolonged interruptions of more than 2 hours per day)	
Facility Type	**Count**	**%**	**Count**	**%**	**Count**	**%**
Family Polyclinic (n=115)	78	68%	24	21%	13	11%
Multidisciplinary Central Polyclinic (n=78)	58	74%	18	23%	2	3%
Family Polyclinic Type 1 (n=72)	33	46%	17	24%	22	31%
Family Polyclinic Type 2 (n=73)	32	44%	25	34%	16	22%
Family Polyclinic Type 2 Branch (n=24)	9	38%	7	29%	8	33%
Grand Total (n=362)	**210**	**58%**	**91**	**25%**	**61**	**17%**

Table 13: Reported frequency and duration of electricity interruptions during facility operating hours, by facility type

4.1.1.2 Presence of backup generators

Backup generators are essential for safe and continuous health care service delivery including cold chain systems, laboratory services, sterilization equipment, communications, digital health platforms, lighting and life-saving medical equipment.

- ☐ 20% (23/115) of Family Polyclinics had a backup generator.
- ☐ 31% (24/78) of Multi-Profile Central Polyclinics had a backup generator.
- ☐ 13% (9/72) of Family Polyclinic Type 1 had a backup generator.
- ☐ 19% (14/73) of Family Polyclinic Type 2 had a backup generator.
- ☐ 0% (0/24) of Family Polyclinic Type 2 Branch had a backup generator.

Backup power capacity was limited across all facility types. Only 70 of 362 surveyed facilities (19%) had a backup generator, many of these were observed to be in poor condition, undersized (small 3kA petrol generators), or lacking fuel or starter batteries.

Coverage was highest in Multidisciplinary Central Polyclinics, at 31%, reflecting their larger scale and pre-reform role as specialist outpatient and diagnostic facilities.

Among first-contact facilities, 20% of pre-reform Family Polyclinics had a backup generator, compared with 13% of Type I Family Polyclinics and 19% of Type II Family Polyclinics. Type II facilities therefore had backup-generator coverage broadly comparable with the previous Family Polyclinic model, while Type I facilities had lower coverage. No Type II Branch had a backup generator.

These findings are particularly important when considered alongside the reported frequency of electricity interruptions. Prolonged interruptions exceeding two hours per day affected 31% of Type I facilities, yet only 13% had a generator. In Type II facilities, 22% experienced prolonged interruptions and 19% had backup generation. The largest mismatch was observed in branches: 33% experienced prolonged interruptions, while none had a backup generator.

Unlike lower onsite availability of selected diagnostic or specialist services, the absence of reliable backup power cannot be explained by intentional service reconfiguration. Electricity is a basic operational requirement for all facility types. Limited backup capacity may interrupt lighting, communications, digital health systems, refrigeration, selected equipment and continuity of clinical services.

The effective level of resilience may be even lower than the reported 19%, as field observations indicated that some installed generators were in poor condition, insufficiently sized or lacked fuel or functioning starter batteries. Generator presence should therefore not be treated as equivalent to functional backup power capacity.

The findings show that the reform has not yet established adequate electrical resilience across the new PHC network. Priority should be given to post-reform facilities with frequent or prolonged power interruptions, particularly Type II Branches and Type I facilities. Type II service hubs should also have reliable backup systems proportionate to their extended operating hours and network responsibilities. Investment should cover not only generator procurement, but also appropriate capacity, installation, maintenance, fuel supply and routine functionality checks.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	23	20%	92	80%
Multidisciplinary Central Polyclinic (n=78)	24	31%	54	69%
Family Polyclinic Type 1 (n=72)	9	13%	63	88%
Family Polyclinic Type 2 (n=73)	14	19%	59	81%
Family Polyclinic Type 2 Branch (n=24)	0	0%	24	100%
Grand Total (n=362)	**70**	**19%**	**292**	**81%**

Table 14: Availability of backup generators by facility type



Figure 8. Underpowered 3kV Backup Generator at Margilan City Multidisciplinary Central Polyclinic, Fergana



Figure 9. Underpowered 3kV Backup Generator at Kustetpa Multidisciplinary Central Polyclinic, Fergana



Figure 10. Underpowered 3kV Backup Generator at Family Polyclinic Type 1 #30, Khatirchi district, Navoi



Figure 11. Underpowered 3kV Backup Generator at Family Polyclinic Type 2 #6, Asaka district, Andijan



Figure 12. Underpowered 3kV Backup Generator at Family Polyclinic #57, Karakul district, Bukhara



Figure 13. Underpowered 3kV Backup Generator at Family Polyclinic # 4, Bukhara District



Figure 14. Underpowered 3kV Backup Generator at Fergana City Multidisciplinary Central Polyclinic



Figure 15. Underpowered 3kV Backup Generator at Family Polyclinic # 64, Shahrikhan City

4.1.1.3 Facilities with solar power

Solar power can provide a useful addition to health facility power supplies particularly during summer months. If the solar battery systems are correctly sized they can also provide temporary electricity supplies during short power cuts.

- ☐ 32% (37/115) of Family Polyclinics had solar systems installed.
- ☐ 49% (38/78) of Multi-Profile Central Polyclinics had solar systems installed.
- ☐ 26% (19/72) of Family Polyclinic Type 1 had solar systems installed.
- ☐ 51% (37/73) of Family Polyclinic Type 2 had solar systems installed.
- ☐ 17% (4/24) of Family Polyclinic Type 2 Branch had solar systems installed.

Solar power systems were installed in 135 of 362 surveyed facilities (37%). Coverage varied substantially by facility type, with the highest proportion observed in Type II Family Polyclinics and Multidisciplinary Central Polyclinics.

Among facilities operating under the pre-reform model, 32% of Family Polyclinics and 49% of MCPs had solar systems. The higher MCP figure should be interpreted separately because these were larger specialist outpatient and diagnostic facilities.

Within the post-reform model, Type II Family Polyclinics recorded the highest solar coverage, at 51%. This was substantially higher than the 32% observed in pre-reform Family Polyclinics and indicates that solar infrastructure has been expanded in the principal service hubs of the new PHC network.

Coverage was lower in Type I Family Polyclinics, at 26%, and lowest in Type II Branches, at 17%. This distribution is important because these facility types also experienced the least reliable grid electricity. Prolonged power interruptions affected 31% of Type I facilities and 33% of branches, while only 13% and 0%, respectively, had backup generators. Solar coverage therefore remains particularly limited in the facilities with the greatest exposure to electricity interruptions.

The presence of a solar system should not, however, be interpreted as confirmation of continuous backup power. The survey recorded whether a system was installed but did not establish its generating capacity, operational condition, battery storage or ability to maintain essential services during an outage.

The findings indicate that solar infrastructure has been incorporated most extensively into Type II Family Polyclinics, representing a positive feature of the post-reform model. The main remaining gap is in Type I facilities and branches, where lower solar coverage coincides with more frequent electricity interruptions and limited generator availability.

Future investment should prioritise functional solar and battery systems in post-reform facilities with unreliable electricity, particularly Type II Branches and Type I Family Polyclinics. System capacity should be matched to the essential electrical load of each facility, with arrangements for installation, maintenance and routine functionality checks. The objective should be reliable power for essential services rather than installation of solar equipment alone.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	37	32%	78	68%
Multidisciplinary Central Polyclinic (n=78)	38	49%	40	51%
Family Polyclinic Type 1 (n=72)	19	26%	53	74%
Family Polyclinic Type 2 (n=73)	37	51%	36	49%
Family Polyclinic Type 2 Branch (n=24)	4	17%	20	83%
Grand Total (n=362)	**135**	**37%**	**227**	**63%**

Table 15: Availability of installed solar power systems by facility type



Figure 16. Solar Installation at Andijan City Multi-Profile Central Polyclinic



Figure 17. Solar Installation at Family Policlinic № 2, Fergana City

4.1.1.4 SARA power tracer indicator (I1) score

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:

The facility routinely has electricity for lights and communication (at a minimum) from any power source during normal working hours and there has not been a break in power for more than 2 hours per day during the past 7 days.

Overall, 301 of 362 facilities (83%) met this standard. The indicator was achieved by 89% of pre-reform Family Polyclinics and 97% of Multidisciplinary Central Polyclinics. MCPs should be interpreted separately because they operated as larger specialist outpatient and diagnostic facilities under the pre-reform model.

Electrical continuity was lower in all three post-reform facility types. The tracer indicator was met by 78% of Type II Family Polyclinics, 69% of Type I Family Polyclinics and 67% of Type II Branches. Compared with pre-reform Family Polyclinics, this represents a difference of 11 percentage points for Type II facilities, 20 percentage points for Type I facilities and 22 percentage points for branches.

The lowest scores were therefore concentrated in Type I facilities and Type II Branches. Nearly one-third of Type I facilities (31%) and one-third of branches (33%) did not meet the SARA standard because they experienced electricity interruptions exceeding two hours per day. Type II facilities performed better, but 22% still failed to meet the indicator despite their role as the principal service hubs within the post-reform network.

The national tracer score of 83% should be interpreted alongside the more detailed electricity findings. Although 83% of facilities met the SARA threshold, only 58% reported completely uninterrupted electricity. Facilities experiencing interruptions of less than two hours per day still receive a positive tracer score. The indicator therefore measures compliance with the SARA minimum standard rather than continuous electricity supply.

Limited backup capacity increases the operational significance of these interruptions. Only 19% of surveyed facilities had a backup generator, including 13% of Type I facilities, 19% of Type II facilities and none of the Type II Branches. Consequently, many facilities experiencing prolonged interruptions did not have a generator to maintain essential services.

The findings identify electrical continuity as a clear infrastructure gap in the post-reform PHC model, particularly in Type I facilities and Type II Branches. Reliable electricity is a basic operational requirement and cannot be explained by the redistribution of clinical or diagnostic functions under the reform.

Investment should prioritise facilities that fail the SARA power tracer, beginning with those reporting interruptions exceeding two hours per day and lacking functional alternative power. Solutions should be based on the essential electrical load and operating arrangements of each facility and should include appropriate backup generation or solar systems with battery storage, together with installation, maintenance and routine functionality checks. The assessment does not provide sufficient evidence to estimate a specific national number or capacity of generators required.

Please note that the full scores for each facility, by type and region can be found in the SARA EXCEL raw data and analysis spreadsheet.

- ☐ **SARA overall electrical continuity tracer score 83% (301/362).**
- ☐ Family Polyclinics scored 89% (102/115).
- ☐ Multi-Profile Central Polyclinics scored 97% (76/78).
- ☐ Family Polyclinic Type 1 scored 69% (50/72).
- ☐ Family Polyclinic Type 2 scored 78% (57/73).
- ☐ Family Polyclinic Type 2 Branch scored 67% (16/24).

The overall SARA tracer indicator scores for electrical power continuity were as follows:

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	102	89%	13	11%
Multidisciplinary Central Polyclinic (n=78)	76	97%	2	3%
Family Polyclinic Type 1 (n=72)	50	69%	22	31%
Family Polyclinic Type 2 (n=73)	57	78%	16	22%
Family Polyclinic Type 2 Branch (n=24)	16	67%	8	33%
Grand Total (n=362)	**301**	**83%**	**61**	**17%**

Table 16: SARA electrical power tracer scores (I1) by facility type

Overall, reliable electricity remains an important infrastructure challenge for primary health care facilities in Uzbekistan, particularly for lower-level primary health care facilities. Given the increasing reliance on electronic medical records, vaccine cold chain equipment, diagnostic devices and digital communications, improving electrical resilience, including backup power where appropriate, should remain a priority for strengthening primary health care readiness. Despite 42% of facilities reporting interruptions to the electricity supply during the previous week and 17% of facilities reporting frequent daily cuts of more than two hours in duration, only 19% were equipped with a backup generator. This indicates that many primary health care facilities remain vulnerable to service disruption during power outages, particularly lower-level facilities where generator coverage was lowest. It is estimated that at least 400 diesel back-up generators of around 30kVA to 100kVA are required to fill the gap, prioritising facilities with a large case load and frequent interruptions.

4.1.2 Water supply (I2)

Improved water supplies are essential in all primary health facilities for handwashing, cleaning, sterilizing, drinking, toilets and general infection prevention control practices. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



The facility has an improved water source defined by UNICEF as piped, public tap, standpipe, tubewell / borehole, protected dug well, protected spring, rainwater. The water source is located inside the facility or within the ground of the facility.

4.1.2.1 Sources of water

The SARA survey asked the question “what is the main source of water for the facility?”.

- ☐ 75% (270/362) piped water.
- ☐ 12% (43/362) borehole.
- ☐ 6% (22/362) protected dug well.
- ☐ 1% (5/362) protected handpump.
- ☐ 1% (5/362) protected spring.
- ☐ 1% (4/362) tanker water.
- ☐ 1% (2/362) unprotected spring.
- ☐ 0% (1/362) unprotected dug well.
- ☐ 3% (10/362) no water source.

The SARA assessment found that piped water was the predominant source of water, available in 75% (270/362) of facilities. However, 25% relied on alternative water sources, with 12% of facilities relying on boreholes and a further 8% using protected wells, handpumps or springs. Ten facilities (3%) reported having no water source for cleaning and other routine purposes, representing a critical gap that may compromise environmental hygiene and infection prevention.

Multidisciplinary Central Polyclinics (90%) had the highest access to piped water, followed by Family Polyclinics (75%), whereas access was lower among Family Polyclinic Type 1 (67%), Family Polyclinic Type 2 (81%), and particularly Family Polyclinic Type 2 Branches (29%). Family Polyclinic Type 2 Branches were the least well served and 25% (6/24) reported having no water source.

Piped water coverage alone does not determine whether a facility meets the SARA tracer, as protected boreholes, wells and springs also qualify as improved sources. Overall, 95% of facilities met the I2 standard. Performance was broadly maintained in the principal post-reform facilities: 94% of Type I and 96% of Type II Family Polyclinics met the standard, compared with 99% of pre-reform Family Polyclinics. MCPs recorded 100%.

The main gap was concentrated in Type II Branches, where only 58% met the improved water source tracer. Six of the 24 branches (25%) reported having no water source, compared with three Type I facilities and one Type II facility. All ten facilities reporting no water source were therefore within the post-reform model.

The absence of water is a fundamental operational deficiency and cannot be explained by the redistribution of services under the reform. It directly limits hand hygiene, environmental cleaning, sanitation and routine infection prevention and control. The priority should be to provide every facility currently without water—particularly Type II Branches—with a reliable improved source located on the premises. Where connection to piped water is not feasible, an appropriate protected source with adequate storage and distribution should be established.

Overall, Type I and Type II Family Polyclinics have broadly maintained access to improved water sources. The clear implementation gap is at branch level, where both low tracer performance and the complete absence of water in one-quarter of surveyed facilities indicate that basic operational requirements have not yet been consistently secured.

Facility Type	Piped	Tubewell/ borehole	Protected dug well	Protected handpump	Protected spring	Tanker truck	Unprotected spring	Unprotected dug well	No water
Family Polyclinic (n=115)	86	19	8	1	1	0	0	0	0
Multidisciplinary Central Polyclinic (n=78)	70	3	5	0	0	0	0	0	0
Family Polyclinic Type 1 (n=72)	48	12	5	1	1	2	0	0	3
Family Polyclinic Type 2 (n=73)	59	6	4	1	0	0	1	1	1
Family Polyclinic Type 2 Branch (n=24)	7	3	0	2	3	2	1	0	6
Grand Total (n=362)	**270**	**43**	**22**	**5**	**5**	**4**	**2**	**1**	**10**

Table 17: Main water source in the health care facility, by facility type



Figure 18. Booster Pump Installation at Family Polyclinic No. 1, Nukus



Figure 19. Booster Pump Installation at Family Polyclinic No. 23, Kungrad



Figure 20. Borehole at Multidisciplinary Central Polyclinic, Kukdala district, Kashkadarya



Figure 21. Water Tower at Multidisciplinary Central Polyclinic, Sariosiyo district, Surkhandarya



Figure 22. Tubewell at Family Polyclinic #92, Sho'rchi district, Surkhandarya



Figure 23. Tubewell at Family Polyclinic #10, Kitab district, Kashkadarya



Figure 24. Water Storage at Multidisciplinary Central Polyclinic, Sherobod district, Surkhandarya



Figure 25. Water Storage at Multidisciplinary Central Polyclinic, Kamashi district, Kashkadarya

4.1.2.2 Water source on premises

Having a safe and available supply of water is not sufficient if it is located offsite more than 500m from the facility. An improved water source located offsite may provide some access to water but does not offer the same level of operational reliability as a source available within the facility or its grounds.

- ☐ 81% (295/362) of facilities had water sources on premises.
- ☐ 13% (48/362) of facilities had water sources located up to 500 metres.
- ☐ 2% (9/362) of facilities had water sources located over 500 metres.
- ☐ 3% (10/362) of facilities had no water source.

Overall, 295 of 362 surveyed facilities (81%) had a water source on premises. A further 48 facilities (13%) obtained water from a source located within 500 metres, nine facilities (2%) relied on a source more than 500 metres away, and ten facilities (3%) had no water source.

- ☐ Access to water on premises was highest in Multidisciplinary Central Polyclinics, at 91%, followed by pre-reform Family Polyclinics at 86%. MCPs should be considered separately because they operated as larger specialist outpatient and diagnostic facilities.
- ☐ Among the principal post-reform facility types, 82% of Type II Family Polyclinics had water on premises, broadly comparable with the 86% recorded in pre-reform Family Polyclinics. Coverage was lower in Type I Family Polyclinics, at 75%. Three Type I facilities had no water source, while two relied on sources located more than 500 metres away.
- ☐ The largest gap was observed in Type II Branches. Only 11 of 24 branches (46%) had water available on premises. Six branches (25%) relied on a source located within 500 metres, one branch (4%) used a source more than 500 metres away, and six branches (25%) had no water source. Type II Branches therefore accounted for six of the ten surveyed facilities without any water supply.
- ☐ The absence of water on premises is a basic infrastructure gap and cannot be attributed to the differentiated service functions of post-reform facilities. It is particularly significant at branch level, where more than half of surveyed facilities lacked an onsite source and one-quarter had no water source at all.
- ☐ The priority should be to ensure that every facility has a reliable improved water source within its premises, beginning with the ten facilities currently reporting no water source and the branches relying on offsite supplies. Where connection to piped water is not feasible, protected sources should be combined with adequate onsite storage and internal distribution to support handwashing, cleaning and sanitation throughout operating hours.
- ☐ Overall, Type II Family Polyclinics have largely maintained the level of onsite water access observed in pre-reform Family Polyclinics. The main implementation gap is concentrated in Type II Branches, where inadequate access to water on premises remains a substantial constraint to safe and consistent service delivery.

	On premises		Up to 500 metres		Over 500 metres		No water source	
Facility Type	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Family Polyclinic (n=115)	99	86%	13	11%	3	3%	0	0%
Multidisciplinary Central Polyclinic (n=78)	71	91%	7	9%	0	0%	0	0%
Family Polyclinic Type 1 (n=72)	54	75%	13	18%	2	3%	3	4%
Family Polyclinic Type 2 (n=73)	60	82%	9	12%	3	4%	1	1%
Family Polyclinic Type 2 Branch (n=24)	11	46%	6	25%	1	4%	6	25%
Grand Total (n=362)	**295**	**81%**	**48**	**13%**	**9**	**2%**	**10**	**3%**

Table 18: Location of the main water source, by facility type

4.1.2.3 Water available during assessment

Access to an improved water source alone is not sufficient to ensure safe and reliable water services within health care facilities, the water supply needs to be available 24 hours a day, 7 days a week.

- ☐ 88% (320/362) of facilities had water available at the time of the survey.
- ☐ 12% (42/362) of facilities had no water available at the time of the survey.

Most facilities 88% (320/362) had water available at the time of the assessment, indicating generally good access to operational water services. However, 12% (42/362) had no water available during the survey, highlighting important gaps in service reliability.

Multidisciplinary Central Polyclinics (96%) and Family Polyclinics (94%) demonstrated the most reliable water supply, whereas Family Polyclinic Type 1 facilities (82%) and Family Polyclinic Type 2 facilities (90%) experienced lower levels of water availability.

The largest gap was observed in Type II Branches. Family Polyclinic Type 2 Branches showed the poorest performance, with only 50% (12/24) having water available at the time of the assessment suggesting substantial deficiencies in basic water services at the smallest facilities.

The absence of water at one in eight facilities represents a significant challenge for infection prevention and control, affecting hand hygiene, environmental cleaning, sanitation and the delivery of safe health care services.

Survey teams observed that water supply problems were frequently related to distribution rather than source availability. In several facilities, water failed to reach all taps because of insufficient pressure, particularly on upper floors, limiting the functionality of handwashing stations, toilets and cleaning facilities.

The findings indicate that Type II Family Polyclinics have largely maintained operational water availability at the level observed in pre-reform Family Polyclinics. The principal implementation gaps are concentrated in Type I facilities and, most substantially, in Type II Branches.

Investment should prioritise the 42 facilities where water was unavailable at the time of assessment, beginning with the 12 affected branches. Measures should address both the availability of a reliable source and the internal storage, pressure and distribution systems required to ensure that water reaches all essential points of use during operating hours.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	108	94%	7	6%
Multidisciplinary Central Polyclinic (n=78)	75	96%	3	4%
Family Polyclinic Type 1 (n=72)	59	82%	13	18%
Family Polyclinic Type 2 (n=73)	66	90%	7	10%
Family Polyclinic Type 2 Branch (n=24)	12	50%	12	50%
Grand Total (n=362)	**320**	**88%**	**42**	**12%**

Table 19: Availability of water at the time of assessment, by facility type

4.1.2.4 SARA water tracer indicator (I2) score

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



The facility has an improved water source defined by UNICEF as piped, public tap, standpipe, tubewell / borehole, protected dug well, protected spring, rainwater. The water source is located inside the facility or within the ground of the facility.

Following the WHO SARA methodology, the overall water tracer indicator score (I2) was 95% (344/362). Multidisciplinary central polyclinics achieved the highest performance 100%, followed by family polyclinics 99%, while family polyclinics type 2 branch scored significantly lower at 58%, highlighting significant inequities in water availability at lower primary health care levels.

The main gap was concentrated in Type II Branches. Only 14 of 24 branches (58%) met the tracer indicator, while ten branches (42%) did not. This difference cannot be explained by the differentiated clinical roles of facilities, as an improved onsite water source is a basic requirement for all health facilities.

Overall, Type I and Type II Family Polyclinics have largely maintained access to improved water sources. The principal implementation gap is at branch level, where 42% of facilities did not meet the SARA standard and half had no water available at the time of assessment.

Investment should prioritise Type II Branches that do not meet the tracer and facilities where an improved source exists but water is not reliably available. Measures should address the complete water-service chain, including the source, onsite storage, pressure and internal distribution to handwashing stations, toilets and cleaning areas.

Please note that the full scores for each facility, by type and region can be found in the SARA EXCEL raw data and analysis spreadsheet.

- ☐ SARA overall water supply tracer indicator score 95% (344/362).
- ☐ Family Polyclinics scored 99% (114/115).
- ☐ Multi-Profile Central Polyclinics scored 100% (78/78).
- ☐ Family Polyclinic Type 1 scored 94% (68/72).
- ☐ Family Polyclinic Type 2 scored 96% (70/73).
- ☐ Family Polyclinic Type 2 Branch scored 58% (14/24).

The overall SARA tracer indicator scores for water supply were as follows:

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	114	99%	1	1%
Multidisciplinary Central Polyclinic (n=78)	78	100%	0	0%
Family Polyclinic Type 1 (n=72)	68	94%	4	6%
Family Polyclinic Type 2 (n=73)	70	96%	3	5%
Family Polyclinic Type 2 Branch (n=24)	14	58%	10	42%
Grand Total (n=362)	**344**	**95%**	**18**	**5%**

Table 20: Facilities meeting the SARA improved water source tracer indicator (I2), by facility type

Overall, reliable water supplies remain an important infrastructure challenge for primary health care facilities in Uzbekistan, particularly for lower-level primary health care facilities. Most primary health care facilities have access to an improved water source; however, one in eight facilities did not have water on the day of the assessment, and survey observations identified low water pressure, aging infrastructure, lack of sufficient storage to buffer breaks in service, and poor distribution within buildings as common operational challenges. Given the importance of water for infection prevention control, water supplies should remain a priority for strengthening primary health care readiness.

4.1.3 Privacy (I3)

Privacy during patient consultations is an essential part of ensuring patient dignity, confidentiality, safety and respect.

4.1.3.1 Consultation room privacy

The SARA survey asked the question "is there a room with auditory and visual privacy available for patient consultations?"

- ☐ 37% (134/362) of facilities reported having rooms with both visual and auditory privacy with the facility.
- ☐ 12% (42/362) offered visual privacy with no auditory privacy.
- ☐ 2% (7/362) offered auditory privacy only with no visual privacy.
- ☐ 49% (179/362) of facilities reported consultation rooms had neither audio nor visual privacy with the facility.

The assessment found that consultation privacy was limited across the primary health care system. Only 51% (183/362) of facilities offered some form of privacy with 37% (134/362) having consultation rooms providing both visual and auditory privacy, while 49% (179/362) had neither, limiting the ability to conduct confidential patient consultations. Privacy was particularly poor in lower-level facilities. Only 19% of Family Polyclinic Type 1 facilities and 13% of Family Polyclinic Type 2 Branches provided both visual and auditory privacy, while 68% and 79%, respectively, offered no privacy.

Multidisciplinary Central Polyclinics recorded the highest level of full consultation privacy, at 56%. This result should be considered separately because MCPs operated as larger specialist outpatient and diagnostic facilities under the pre-reform model.

Among comparable first-contact facilities, 40% of pre-reform Family Polyclinics and 37% of Type II Family Polyclinics had both auditory and visual privacy. Type II facilities therefore broadly maintained the already low level observed in the previous Family Polyclinic model. However, more than half of Type II facilities (52%) still had no consultation privacy.

Conditions were weaker in Type I Family Polyclinics. Only 19% had both auditory and visual privacy, while 68% had neither. Type II Branches recorded the lowest level of privacy: only three of 24 branches (13%) had both forms of privacy, and 19 branches (79%) had neither.

The findings demonstrate that inadequate consultation privacy is a system-wide problem rather than an issue confined to one facility type. However, the gap is substantially greater in Type I facilities and branches. This cannot be explained by the differentiated service functions of the post-reform model, as confidential consultation space is required in every facility providing direct patient care.

Improvement should prioritise the 179 facilities with neither auditory nor visual privacy, particularly Type I Family Polyclinics and Type II Branches. Each facility should have at least one consultation space that prevents patients from being seen or overheard, using appropriate doors, partitions and room arrangements. The indicator records the availability of such a room but does not establish whether it is consistently used for confidential consultations.

Overall, Type II Family Polyclinics have broadly retained the level of consultation privacy observed in pre-reform Family Polyclinics, but that level remains inadequate. The clearest post-reform implementation gaps are in Type I facilities and branches, where most facilities cannot provide consultations with both visual and auditory privacy.

	Both auditory and visual privacy		**Auditory privacy only**		**Visual privacy only**		**No privacy**	
Facility Type	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Family Polyclinic (n=115)	46	40%	19	17%	3	3%	47	41%
Multidisciplinary Central Polyclinic (n=78)	44	56%	6	8%	2	3%	26	33%
Family Polyclinic Type 1 (n=72)	14	19%	8	11%	1	1%	49	68%
Family Polyclinic Type 2 (n=73)	27	37%	7	10%	1	1%	38	52%
Family Polyclinic Type 2 Branch (n=24)	3	13%	2	8%	0	0%	19	79%
Grand Total (n=362)	**134**	**37%**	**42**	**12%**	**7**	**2%**	**179**	**49%**

Table 21: Availability of auditory and visual privacy for patient consultations, by facility type

4.1.3.2 SARA privacy tracer indicator (I3) score

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



The facility has a private room or screened off area available in main service area (usually the general outpatient service area), a sufficient distance from sites where providers/clients routinely may be, so that a normal conversation could be held without being overheard, and without the client being observed.

Following the WHO SARA methodology, the overall privacy tracer indicator score (I3) was 37% (134/362). Overall, 134 of 362 surveyed facilities (37%) met this standard, while 228 facilities (63%) did not. Consultation privacy was therefore inadequate across the PHC network.

Multidisciplinary Central Polyclinics recorded the highest score, at 56%. This result should be interpreted separately because MCPs operated as larger specialist outpatient and diagnostic facilities under the pre-reform model.

Among comparable first-contact facilities, 40% of pre-reform Family Polyclinics and 37% of Type II Family Polyclinics met the privacy standard. Type II facilities therefore broadly maintained the level observed in the previous Family Polyclinic model, although readiness remained low in both facility types.

Performance was substantially weaker in Type I Family Polyclinics and Type II Branches. Only 19% of Type I facilities and 13% of branches met the indicator. Consequently, 81% of Type I facilities and 87% of branches lacked a consultation area providing both auditory and visual privacy.

The findings identify inadequate consultation privacy as a system-wide quality-of-care problem, with the largest gaps concentrated in Type I facilities and branches. The difference cannot be explained by the redistribution of specialist or diagnostic functions, as confidential consultation space is required in every facility providing direct patient care.

Lack of privacy may limit confidential communication, particularly during family planning, adolescent health, mental health, HIV counselling and gender-based violence consultations. The indicator confirms whether a suitable space is available but does not establish whether it is consistently used during patient consultations.

Improvement should prioritise the 228 facilities that did not meet the SARA standard, particularly Type I Family Polyclinics and Type II Branches. Depending on the facility layout, measures may include designating a separate consultation room, installing doors or fixed partitions, improving sound separation, rearranging consultation areas or using appropriate privacy screens where permanent structural changes are not immediately feasible.

Overall, Type II Family Polyclinics have maintained privacy readiness at approximately the level of pre-reform Family Polyclinics, but that level remains inadequate. The clearest post-reform gaps are in Type I facilities and branches, where fewer than one in five facilities met the minimum SARA privacy standard.

Please note that the full scores for each facility, by type and region can be found in the SARA EXCEL raw data and analysis spreadsheet.

- ☐ **SARA overall privacy tracer indicator score 37% (134/362).**
- ☐ Family Polyclinics scored 40% (46/115).
- ☐ Multi-Profile Central Polyclinics scored 56% (44/78).
- ☐ Family Polyclinic Type 1 scored 19% (14/72).
- ☐ Family Polyclinic Type 2 scored 37% (27/73).
- ☐ Family Polyclinic Type 2 Branch scored 13% (3/24).

The overall SARA tracer indicator scores for privacy were as follows:

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	46	40%	69	60%
Multidisciplinary Central Polyclinic (n=78)	44	56%	34	44%
Family Polyclinic Type 1 (n=72)	14	19%	58	81%
Family Polyclinic Type 2 (n=73)	27	37%	46	63%
Family Polyclinic Type 2 Branch (n=24)	3	13%	21	87%
Grand Total (n=362)	**134**	**37%**	**228**	**63%**

Table 22: Facilities meeting the SARA consultation privacy tracer indicator (I3), by facility type

Overall, privacy remains an important infrastructure challenge for primary health care facilities in Uzbekistan, particularly for lower-level primary health care facilities. Only one in three primary health care facilities provided consultation rooms with both visual and auditory privacy, while almost half offered neither. This represents an important gap in patient confidentiality and may discourage patients from openly discussing sensitive health conditions. Improving consultation privacy should be considered an important component of quality primary health care. Private consultation rooms support patient confidentiality, informed consent and effective communication, particularly for sensitive services such as family planning, adolescent health, mental health, HIV counselling and gender-based violence. Unlike some infrastructure improvements, consultation privacy is often achievable through relatively simple and low-cost interventions, such as (i) installing partitions, (ii) improving sound insulation, (iii) redesigning consultation layouts, or (iv) using privacy screens where space is limited.

4.1.4 Sanitation (I4)

Proper toilets are crucial for preventing the spread of diseases and ensuring dignity and safety for staff, patients, and caregivers. Health care facilities must have clean, well-maintained, and adequate toilets with separate toilets for staff and patients. Female toilets should have specific provisions for menstrual hygiene management, including disposal bins and washing areas with soap and water.

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



The toilet/latrine is classified using uniform criteria for improved sanitation promoted by UNICEF. These include the following: Flush/ pour flush to piped sewer system or septic tank or pit latrine, pit latrine (ventilated improved pit (VIP) or other) with slab, composting toilet. There are adequate sanitation facilities accessible (unlocked or key available) for clients on premises.

4.1.4.1 Available toilet for general outpatient use

The SARA survey asked the question "Is there a functioning toilet on premises that is accessible for general outpatient use?

- ☐ 94% (339/362) of facilities had at least one functioning toilet on premises that is accessible for general outpatient use.
- ☐ 6% (23/362) had no functioning toilet on premises that is accessible for general outpatient use.

The SARA assessment found that access to basic sanitation was generally reasonable, with 94% (339/362) of surveyed facilities providing a functioning toilet accessible for general outpatient use however as you will see from the following sections a large number were pit latrines in poor condition, and the coverage of number of available toilets per number of daily outpatient visits was worrying. In addition, 6% (23/362) of facilities lacked a functioning outpatient toilet which is concerning.

Access was nearly universal in facilities operating under the pre-reform model: 99% of both Family Polyclinics and Multidisciplinary Central Polyclinics had a functioning outpatient toilet. MCPs should be interpreted separately because they operated as larger specialist outpatient and diagnostic facilities.

Among the principal post-reform facility types, 93% of both Type I and Type II Family Polyclinics had at least one functioning outpatient toilet. These results were close to the 99% recorded in pre-reform Family Polyclinics, indicating that basic outpatient sanitation access has largely been maintained in Type I and Type II facilities. Nevertheless, five facilities of each type lacked a functioning toilet.

The main gap was concentrated in Type II Branches. Only 13 of 24 branches (54%) had a functioning toilet accessible to outpatients, while 11 branches (46%) had none. Although branches represented only 24 of the 362 surveyed facilities, they accounted for nearly half of all facilities without a functioning outpatient toilet.

The absence of a functioning toilet is a fundamental infrastructure deficiency and cannot be explained by the differentiated service roles of post-reform facilities. It affects patient dignity, sanitation and the safe operation of any facility providing direct outpatient care.

Priority should therefore be given to installing or restoring at least one functioning outpatient toilet in the 23 facilities that lacked one, beginning with the 11 affected Type II Branches. Overall, Type I and Type II Family Polyclinics have broadly maintained the high level of basic sanitation access observed in pre-reform Family Polyclinics, while Type II Branches remain the clear implementation gap.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	114	99%	1	1%
Multidisciplinary Central Polyclinic (n=78)	77	99%	1	1%
Family Polyclinic Type 1 (n=72)	67	93%	5	7%
Family Polyclinic Type 2 (n=73)	68	93%	5	7%
Family Polyclinic Type 2 Branch (n=24)	13	54%	11	46%
Grand Total (n=362)	**339**	**94%**	**23**	**6%**

Table 23: Availability of at least one functioning toilet accessible to general outpatients, by facility type



Figure 26. Pit Latrine at Family Polyclinic # 47, Shafirkan, Bukhara



Figure 27. Pit Latrine at Family Policlinic Type 2 Branch № 3, Syrdarya District, Syrdarya



Figure 28. Pit Latrine at Multidisciplinary Central Polyclinic, Boz, Andijan



Figure 29. Pit Latrine at Multidisciplinary Central Polyclinic, Kurgantepa, Andijan

4.1.4.2 Types of toilets

Improved toilets are defined as those designed to hygienically separate excreta from human contact. Improved sanitation facilities are those designed to hygienically separate excreta from human contact. Improved facilities include: flush/pour flush to piped sewer system, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs.

- ☐ 64% (232/362) of facilities reported they had flush toilets available to visitors.
- ☐ 30% (107/362) reported they had pit latrines with slabs available to visitors.
- ☐ 6% (23/362) no functional toilets.

The SARA assessment found that flush toilets were the predominant sanitation type, available in 64% (232/362) of primary health care facilities. However, 30% (107/362) relied on pit latrines with slabs, indicating that a substantial proportion of facilities continue to use lower-service sanitation facilities.

Multidisciplinary Central Polyclinics (77%) had the highest proportion of flush toilets, followed by Family Polyclinics (63%), reflecting generally better sanitation infrastructure at larger facilities. Approximately one-third of Family Polyclinic Type 1 facilities (36%) and one-quarter of Family Polyclinic Type 2 facilities (23%) relied on pit latrines, suggesting that lower-level facilities are more dependent on basic sanitation systems. Family Polyclinic Type 2 Branches had the poorest sanitation infrastructure, with only 29% (7/24) equipped with flush toilets, 25% relying on pit latrines, and 46% lacking a functioning toilet for general outpatient use.

Facility Type	Flush toilet	Pit latrine with slab	No toilet for general use
Family Polyclinic (n=115)	73	41	1
Multidisciplinary Central Polyclinic (n=78)	60	17	1
Family Polyclinic Type 1 (n=72)	41	26	5
Family Polyclinic Type 2 (n=73)	51	17	5
Family Polyclinic Type 2 Branch (n=24)	7	6	11
Grand Total (n=362)	**232**	**107**	**23**

Table 24: Type of functioning toilet available for general outpatient use, by facility type

Although almost all primary health care facilities had access to a functioning toilet, only two-thirds provided flush sanitation, while one-third relied on pit latrines or had no functional toilet. The greatest deficiencies were observed in smaller satellite facilities. Future investments should focus on upgrading basic sanitation infrastructure, particularly in lower-level facilities where pit latrines remain common. Transitioning to safely managed flush sanitation would improve patient dignity, accessibility, infection prevention and environmental health, and would better align with WHO/UNICEF WASH in Health Care Facility standards.

Overall, Type II Family Polyclinics have maintained a sanitation profile comparable to or better than pre-reform Family Polyclinics. The principal post-reform gap is concentrated in Type II Branches, where nearly half lacked any functioning toilet for general outpatient use.



Figure 30. Pit Latrine at Amudarya Multidisciplinary Central Polyclinic, Karakalpakstan



Figure 31. Pit Latrine at Family Polyclinic # 8, Mingbuloq, Namangan



Figure 32. Pit Latrine at Family Polyclinic # 100, Rishton



Figure 33. Pit Latrine at Family Policlinic № 10 Fergana

4.1.4.3 Sufficient numbers of toilets

Health care facilities should be equipped with sufficient numbers of toilets for staff, patients and care givers with privacy and dignity.

- ☐ Average of 3.3 functional toilets per family polyclinic.
- ☐ Average of 6.5 functional toilets per multidisciplinary central polyclinic.
- ☐ Average of 2.8 functional toilets per family polyclinic (type I).
- ☐ Average of 4.5 functional toilets per family polyclinic (type II).
- ☐ Average of 0.9 functional toilets per family polyclinic (type II branch).

The assessment found that there was an average of 4.0 functional toilets per primary health care facility, although substantial variation was observed between facility types, reflecting differences in facility size and service complexity.

Facility Type	Average of 421c. How many toilets in total are available?
Family Polyclinic (n=115)	3.3
Multidisciplinary Central Polyclinic (n=78)	6.5
Family Polyclinic Type 1 (n=72)	2.8
Family Polyclinic Type 2 (n=73)	4.5
Family Polyclinic Type 2 Branch (n=24)	0.9
Average (n=362)	**4.0**

Table 25: Average number of functional toilets per facility by facility type

Considering the high variability in average number of outpatients per day that are using each type of facility, the next table, showing averages number of outpatient visitors per toilet, offers a better insight into whether there are sufficient numbers.

- ☐ Average of 308 outpatient visitors per functional toilet in MCPs.
- ☐ Average of 42 outpatient visitors per functional toilet in family polyclinics type I.
- ☐ Average of 89 outpatient visitors per functional toilet in family polyclinics type 2.
- ☐ Average of 10 outpatient visitors per functional toilet in family polyclinics type 2 branch.

On average, primary health care facilities only had a coverage of one functional toilet for every 123 outpatient visits per day, although toilet coverage varied substantially between facility types. Multidisciplinary Central Polyclinics experienced the highest demand, averaging 308 outpatient visitors per functional toilet, almost four times the ratio observed in Family Polyclinics (81 visitors per toilet). This reflects their much higher patient workload and suggests greater pressure on sanitation facilities. Family Polyclinic Type 1 facilities had the lowest patient-to-toilet ratio among the main facility types (42 outpatient visits per toilet), indicating comparatively good toilet availability relative to patient workload. Family Polyclinic Type 2 facilities averaged 89 outpatient visits per functional toilet, representing a moderate level of toilet demand. Family Polyclinic Type 2 Branches averaged only 10 outpatient visits per toilet, reflecting their relatively low patient volumes rather than superior sanitation infrastructure. This indicator should therefore be interpreted alongside the finding that almost half of these facilities lacked a functioning toilet altogether.

Facility Type	Average of CALCULATED FIELD #OUTPATIENT VISITORS / TOILET
Family Polyclinic (n=115)	81
Multidisciplinary Central Polyclinic (n=78)	308
Family Polyclinic Type 1 (n=72)	42
Family Polyclinic Type 2 (n=73)	89
Family Polyclinic Type 2 Branch (n=24)	10
Average (n=362)	**123**

Table 26: Average number of daily outpatient visits per functional toilet by facility type

Among the 78 multidisciplinary central polyclinics, Amudaryo MCP in Tashkent Region stood out with only 2 functional toilets and an average of 3,400 outpatient visits per day. Similarly, Kushtepa MCP in Fergana had only 2 functional toilets and an average of 2,200 outpatient visitors per day.

The clearest gaps are the complete absence of functioning toilets in many branches and excessive pressure on sanitation facilities in selected high-volume MCPs. The data describe toilet availability and workload but do not establish compliance with a specific national or international patient-to-toilet standard.

4.1.4.4 Toilets clearly separated for staff and patients

Ideally staff should be able to access dedicated and separate toilets from patients to ensure privacy, dignity, and safety. Uzbekistan SanPiN No. 0292-11: Design, Construction and Operation of Health care Facilities clearly states in section 3.7 that health care facilities must have separate toilets for patients and staff, except in locations that have less than 50 visits per shift.

- ☐ 44% (158/362) had dedicated toilets just for staff
- ☐ 56% (204/362) did not have a dedicated toilet just for staff

The assessment found that less than half (158/362) of surveyed facilities had a dedicated toilet for staff, while 56% (204/362) required staff and patients to share toilet facilities. Multidisciplinary Central Polyclinics were the best equipped, with 58% providing dedicated staff toilets, reflecting their larger size and greater infrastructure capacity.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	49	43%	66	57%
Multidisciplinary Central Polyclinic (n=78)	45	58%	33	42%
Family Polyclinic Type 1 (n=72)	29	40%	43	60%
Family Polyclinic Type 2 (n=73)	30	41%	43	59%
Family Polyclinic Type 2 Branch (n=24)	5	21%	19	79%
Average (n=362)	**158**	**44%**	**204**	**56%**

Table 27: Availability of toilets dedicated to staff, by facility type

Dedicated staff sanitation facilities were not routinely available across primary health care facilities with only 44% (158/362) of surveyed facilities had a dedicated staff toilet. This is substantially below the expectations of Uzbekistan SanPiN No. 0292-11, which requires separate toilets for patients and staff in health care facilities, except for outpatient facilities with fewer than 50 visits per shift. Where space and resources permit, provision of separate staff toilets should be considered in future facility upgrades. Dedicated staff sanitation facilities improve staff welfare, preserve patient toilet availability, and support good infection prevention and control practices by reducing unnecessary sharing of facilities.

Multidisciplinary Central Polyclinics recorded the highest availability of dedicated staff toilets, at 58%. This result should be interpreted separately because MCPs operated as larger specialist outpatient and diagnostic facilities with substantially higher patient volumes.

Among comparable first-contact facilities, the availability of dedicated staff toilets was similar across the pre-reform and principal post-reform models. Dedicated staff toilets were available in 43% of pre-reform Family Polyclinics, 40% of Type I Family Polyclinics and 41% of Type II Family Polyclinics. These findings indicate that the reform has not materially changed the availability of separate staff sanitation facilities in Type I and Type II facilities. However, most facilities in all three groups continued to rely on shared toilets.

Type II Branches recorded the lowest availability, with only five of 24 facilities (21%) providing a dedicated staff toilet. Nineteen branches (79%) had no separate staff sanitation facility.

The priority should be to ensure separate staff and patient toilets in facilities that meet or exceed the regulatory threshold of 50 visits per shift. This is particularly relevant for higher-volume Family Polyclinics, Type II Family Polyclinics and MCPs. Where facilities fall below the threshold, shared sanitation should still be functional, hygienic and sufficient for both patients and staff.

Overall, dedicated staff sanitation was not routinely available in either the pre-reform or post-reform PHC models. Type I and Type II Family Polyclinics performed at approximately the same level as pre-reform Family Polyclinics, while Type II Branches recorded the lowest availability, although the regulatory exemption may apply to some branch facilities.

4.1.4.5 Functioning hand hygiene stations within 5 meters of toilets

All toilets in a health facility should be equipped with a functioning handwashing place equipped with soap and water to ensure proper hand hygiene.

- ☐ 81% (293/362) of facilities had functional handwashing facilities with soap and water near toilets.
- ☐ 13% (46/362) did not have functional handwashing facilities with soap and water near toilets.
- ☐ 6% (23/362) had no functional toilets.

The assessment found that most facilities (293/362) had functional handwashing facilities with soap and water located within 5 metres of toilets, supporting good hand hygiene practices following toilet use. Conversely, almost one in five facilities (19%) either lacked functional handwashing facilities near toilets or had no functional toilets, representing an important gap in infection prevention and control infrastructure.

Multidisciplinary Central Polyclinics demonstrated the highest level of compliance, with 90% providing functional handwashing facilities near toilets, followed by Family Polyclinics (84%). Family Polyclinic Type 1 (79%) and Family Polyclinic Type 2 (82%) also achieved relatively high coverage, although approximately one in six Type 1 facilities and one in nine Type 2 facilities lacked handwashing facilities adjacent to toilets.

Family Polyclinic Type 2 Branches performed substantially worse than all other facility types. Only 38% (9/24) had functional handwashing facilities near toilets, while 46% had no functional toilets at all.

	Yes		No		No toilets	
Facility Type	**Count**	**%**	**Count**	**%**	**Count**	**%**
Family Polyclinic (n=115)	97	84%	17	15%	1	1%
Multidisciplinary Central Polyclinic (n=78)	70	90%	6	8%	2	3%
Family Polyclinic Type 1 (n=72)	57	79%	11	15%	4	6%
Family Polyclinic Type 2 (n=73)	60	82%	8	11%	5	7%
Family Polyclinic Type 2 Branch (n=24)	9	38%	4	17%	11	46%
Average (n=362)	**293**	**81%**	**46**	**13%**	**23**	**6%**

Table 28: Availability of functioning hand hygiene stations with soap and water within five metres of toilets, by facility type

Hand hygiene infrastructure was generally well established in larger primary health care facilities, but almost one in five facilities lacked either functional handwashing facilities near toilets or functional toilets altogether. Deficiencies were concentrated in lower-level facilities, particularly Family Polyclinic Type 2 Branches. Universal provision of handwashing facilities with soap and water adjacent to toilets should remain a priority for strengthening infection prevention and control. These are relatively low-cost interventions that can substantially reduce the risk of health care-associated infections while improving compliance with WHO and WHO/UNICEF JMP WASH standards.



Figure 34. Handwashing Sink with No Soap at Family Polyclinic No. 1, Nukus City



Figure 35. Handwashing Sink with Soap at Kagan City Multidisciplinary Central Polyclinic

4.1.4.6 SARA sanitation tracer indicator (I4) score

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



The toilet/latrine is classified using uniform criteria for improved sanitation promoted by UNICEF. These include the following: Flush/ pour flush to piped sewer system or septic tank or pit latrine, pit latrine (ventilated improved pit (VIP) or other) with slab, composting toilet. There are adequate sanitation facilities accessible (unlocked or key available) for clients on premises.

Following the WHO SARA methodology, the overall sanitation tracer indicator score (I4) was 94% (339/362). Multidisciplinary central polyclinics and family polyclinics achieved the highest performance with 99%, followed by type 1 and type 2 family polyclinics with 93%, while family polyclinics type II branch scored significantly lower at 54%. Please note that the full scores for each facility, by type and region can be found in the SARA EXCEL raw data and analysis spreadsheet.

- ☐ **SARA overall sanitation tracer indicator score 94% (344/362).**
- ☐ Family Polyclinics scored 99% (114/115).
- ☐ Multi-Profile Central Polyclinics scored 99% (77/78).
- ☐ Family Polyclinic Type 1 scored 93% (67/72).
- ☐ Family Polyclinic Type 2 scored 93% (68/73).
- ☐ Family Polyclinic Type 2 Branch scored 54% (13/24).

The overall SARA tracer indicator scores for sanitation were as follows:

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	114	99%	1	1%
Multidisciplinary Central Polyclinic (n=78)	77	99%	1	1%
Family Polyclinic Type 1 (n=72)	67	93%	5	7%
Family Polyclinic Type 2 (n=73)	68	93%	5	7%
Family Polyclinic Type 2 Branch (n=24)	13	54%	11	46%
Average (n=362)	**339**	**94%**	**23**	**6%**

Table 29: SARA sanitation tracer indicator (I4) scores by facility type

Although the WHO SARA methodology assesses the presence of functional improved sanitation facilities, it does not consider whether there are enough functional toilets available in relation to patient workload. To provide additional operational context, an additional planning indicator - the average number of daily outpatient visits per functional toilet - was developed by the consultant. Facilities with exceptionally high patient-to-toilet ratios may require further assessment, even where they meet the WHO SARA sanitation tracer definition of having at least one functional improved toilet.

Supplementary Planning Indicator: Toilet Coverage (Number of Daily Visitors per Functional Toilet)

Rationale:

The WHO SARA methodology defines a facility to be ready if there is at least one improved functional toilet available for visitors. However, this definition does not assess whether there are enough toilets to meet patient demand. To provide additional operational context, a supplementary toilet coverage indicator is suggested for this assessment.

Working definition:

A facility is considered to have adequate toilet capacity if it provides at least one functional improved toilet for every 120 average daily outpatient visitors. This is the equivalent of 1 improved toilet for every 15 visitors at any stage during the course of the day.

Planning assumption

The facility has an 8-hour outpatient working day. Average patient stay of approximately 1 hour. One toilet for 120 visitors over the course of a day is equivalent to approximately one functional toilet present for every 15 visitors at any one time. The coverage figure meets international recommendations and the 1:15 value found in Uzbekistan SanPiN No. 0292-11: Design, Construction and Operation of Health care Facilities.

Purpose:

This indicator is not part of the WHO SARA methodology and does not affect the official SARA readiness score. It is intended solely as a planning tool to identify facilities where sanitation capacity may warrant further investigation (for example Amudaryo MCP in Tashkent Region with only 2 functional toilets and an average of 3,400 outpatient visits per day, or Kushtepa MCP in Fergana with only 2 functional toilets and an average of 2,200 outpatient visitors per day).

Based on this new metric, only 66% (240/362) of surveyed facilities met the planning benchmark of at least one functional toilet per 120 average daily outpatient visits. Family Polyclinic Type 1 (88%) demonstrated the strongest toilet coverage relative to patient workload, followed by Family Polyclinics (78%) and Family Polyclinic Type 2 facilities (78%). Multidisciplinary Central Polyclinics had the lowest toilet coverage, with only 22% (17/78) meeting the benchmark. In total 78% (61/78) exceeded 120 outpatient visits per functional toilet, indicating substantially greater pressure on sanitation facilities than other facility types. Only 54% (13/24) of Family Polyclinic Type II Branches met the benchmark. However, this reflects relatively low numbers of consultations in these facilities and the high number of type 2 branch facilities with no toilets.

- ☐ 78% (90/115) of family polyclinics have at least 1 functional toilet per 120 daily outpatient visitors.
- ☐ 22% (17/78) of multidisciplinary central polyclinics have at least 1 functional toilet per 120 daily outpatient visitors.
- ☐ 88% (63/72) of type I family polyclinics have at least 1 functional toilet per 120 daily outpatient visitors.
- ☐ 78% (57/73) of type II family polyclinics have at least 1 functional toilet per 120 daily outpatient visitors.
- ☐ 54% (13/24) of type II branch family polyclinics have at least 1 functional toilet per 120 daily outpatient visitors.

When toilet provision is considered in relation to patient workload, important differences emerge between facility types. While most Family Polyclinics met the planning benchmark, the majority of Multidisciplinary Central Polyclinics did not, suggesting that sanitation capacity should be reviewed in facilities experiencing very high outpatient workloads. It should be noted that while this indicator was developed to provide additional operational context, it is not part of the WHO SARA methodology and should therefore be interpreted as a planning tool rather than an official SARA readiness indicator.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	90	78%	25	22%
Multidisciplinary Central Polyclinic (n=78)	17	22%	61	78%
Family Polyclinic Type 1 (n=72)	63	88%	9	13%
Family Polyclinic Type 2 (n=73)	57	78%	16	22%
Family Polyclinic Type 2 Branch (n=24)	13	54%	11	46%
Grand Total (n=362)	**240**	**66%**	**122**	**34%**

Table 30: Revised SARA sanitation tracer indicator (DO4) scores by facility type

Overall, the findings indicate that basic sanitation facilities are widely available across primary health care facilities in Uzbekistan, as reflected by the high WHO SARA sanitation score of 94% (339/362). However, the supplementary coverage to visitors analysis suggests that sanitation capacity may be insufficient in some high-volume facilities, particularly Multidisciplinary Central Polyclinics which have an average of 1 toilet for 308 daily visitors. In addition, almost one-third of facilities continue to rely on pit latrines rather than flush sanitation. Future investments should therefore focus not only on ensuring the availability of improved sanitation facilities, but also on upgrading sanitation quality and ensuring sufficient toilet quantity to meet patient demand.

4.1.5 Communication (I5)

Reliable communication systems are essential for the safe and effective delivery of primary health care services. They enable health workers to consult with specialists, arrange patient referrals, request emergency transport, coordinate with laboratories and pharmacies, report notifiable diseases, and maintain continuity of care. Communication equipment also plays a critical role during medical emergencies and public health events by supporting rapid information exchange between health care facilities and higher levels of the health system. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Functioning communication equipment. This will not include private cell phones unless the facility reimburses for cost of phone calls. This will not include payphones outside of the facility.

As it is possible to have either a VoIP or video conversation over Telegram, this tracer indicator was awarded if the facility EITHER had a functioning landline on the day of the visit OR had mobile coverage on the day of the visit OR had a functioning internet connection on the day of the visit.

4.1.5.1 Functioning hand hygiene stations within 5 meters of toilets

The SARA survey asked the question "does this facility have a functioning land line telephone?"

- ☐ 34% (122/362) of facilities had a functioning land line telephone.
- ☐ 66% (240/362) have no land line telephone.

The survey found only one-third (34%; 122/362) of primary health care facilities had a functioning landline telephone. Multidisciplinary Central Polyclinics had the highest availability of landline telephones, with 56% equipped with a functioning landline, reflecting their larger size and greater coordination responsibilities. Landline availability was considerably lower in Family Polyclinics (34%), Family Polyclinic Type 1 (24%), and Family Polyclinic Type 2 (27%). Family Polyclinic Type 2 Branches had the lowest coverage, with only 8% (2/24) having a functioning landline telephone.

The low availability of landline telephones should be interpreted alongside the availability of mobile phone coverage and VoIP internet connectivity. In many facilities, mobile communications or VoIP may provide an adequate alternative for routine communication. However, reliance on mobile networks alone may reduce communication resilience during network outages, emergencies or power failures.

The priority should therefore not be to install landlines universally. Rather, every facility should have at least one reliable communication channel for routine coordination, referrals and urgent communication. Particular attention should be given to Type I facilities and Type II Branches, where fixed-line availability was lowest, and to ensuring dependable communication between these facilities and their linked Type II Family Polyclinic.

Where communication relies on mobile or internet-based systems, their operational reliability should be considered together with local network coverage and electricity continuity. Type II Family Polyclinics, as the main service hubs within the post-reform network, should be able to maintain regular communication with all linked facilities during operating hours.

Overall, landline availability is not an appropriate standalone measure of communication readiness. The operational priority is reliable connectivity across the post-reform PHC network rather than the provision of a fixed telephone line in every facility.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	39	34%	76	66%
Multidisciplinary Central Polyclinic (n=78)	44	56%	34	44%
Family Polyclinic Type 1 (n=72)	17	24%	55	76%
Family Polyclinic Type 2 (n=73)	20	27%	53	73%
Family Polyclinic Type 2 Branch (n=24)	2	8%	22	92%
Grand Total (n=362)	**122**	**34%**	**240**	**66%**

Table 31: Availability of functioning land line by facility type

4.1.5.2 Functioning cellular coverage

The SARA survey asked the question "does this facility have a functioning cellular telephone coverage?"

- ☐ 74% (267/362) had cellular telephone coverage on the day of the visit.
- ☐ 26% (95/362) have no cellular telephone coverage.

The survey found three-quarters 74% (267/362) of primary health care facilities had cellular telephone coverage, while 26% (95/362) reported no cellular coverage, potentially limiting communication, referrals and emergency coordination.

Multidisciplinary Central Polyclinics had the highest level of cellular coverage (83%), followed by Family Polyclinics (77%), indicating relatively good mobile network availability at larger facilities. Coverage was lower in Family Polyclinic Type 1 (69%) and Family Polyclinic Type 2 (71%) facilities, meaning that almost one-third of these facilities operated without reliable cellular communications. Family Polyclinic Type 2 Branches experienced the poorest connectivity, with only 50% (12/24) reporting cellular coverage. Half of these facilities had no mobile network coverage, potentially affecting communication with referral facilities and emergency services.

Although cellular coverage was substantially more common than landline telephones (74% versus 34%), one in four facilities still lacked access to mobile communications, highlighting an important gap in communication infrastructure, particularly in smaller and more remote facilities.

The priority should be to ensure that every post-reform facility has at least one reliable communication channel during operating hours. Action should focus first on Type II Branches and Type I facilities without cellular coverage, followed by Type II facilities that cannot maintain dependable communication with linked facilities and referral services. Where mobile coverage cannot be improved promptly, alternative arrangements should be established through functioning landlines or reliable internet-based communication.

Overall, the most significant operational gap is at branch level, where half of facilities lacked mobile coverage despite their dependence on regular communication with the Type II service hub.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	88	77%	27	23%
Multidisciplinary Central Polyclinic (n=78)	65	83%	13	17%
Family Polyclinic Type 1 (n=72)	50	69%	22	31%
Family Polyclinic Type 2 (n=73)	52	71%	21	29%
Family Polyclinic Type 2 Branch (n=24)	12	50%	12	50%
Grand Total (n=362)	**267**	**74%**	**95**	**26%**

Table 32: Availability of functioning cellular coverage by facility type

4.1.5.3 SARA communication tracer indicator (I5) score

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Functioning communication equipment. This will not include private cell phones unless the facility reimburses for cost of phone calls. This will not include payphones outside of the facility.

As it is possible to have either a VoIP or video conversation over Telegram in addition to a land line or cell phone, this tracer indicator was awarded if the facility EITHER had a functioning landline on the day of the visit OR had mobile coverage on the day of the visit OR had a functioning internet connection on the day of the visit.

The survey found that overall communication readiness was very high, with 97% (350/362) of surveyed facilities having at least one functioning means of communication (landline telephone, cellular network coverage or internet access) on the day of the assessment. Only 3% (12/362) lacked all three communication methods.

All Multidisciplinary Central Polyclinics (100%) and Family Polyclinic Type 1 facilities (100%) met the WHO SARA communication tracer, demonstrating universal access to at least one functioning communication system. Family Polyclinics (98%) and Family Polyclinic Type 2 facilities (97%) also achieved very high communication readiness, indicating that reliable communication infrastructure is available across almost all primary health care facilities. Family Polyclinic Type 2 Branches performed substantially less well, with only 67% (16/24) meeting the SARA communication indicator. One-third (33%) lacked any functioning communication method on the day of the assessment.

Following the WHO SARA methodology, the overall communication tracer indicator score (I5) was 97% (350/362). Please note that the full scores for each facility, by type and region can be found in the SARA EXCEL raw data and analysis spreadsheet.

- ☐ **SARA overall communication tracer indicator score 97% (350/362).**
- ☐ Family Polyclinics scored 98% (113/115).
- ☐ Multi-Profile Central Polyclinics scored 100% (78/78).
- ☐ Family Polyclinic Type 1 scored 100% (72/72).
- ☐ Family Polyclinic Type 2 scored 97% (71/73).
- ☐ Family Polyclinic Type 2 Branch scored 67% (16/24).

The overall SARA tracer indicator scores for communication were as follows:

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	113	98%	2	2%
Multidisciplinary Central Polyclinic (n=78)	78	100%	0	0%
Family Polyclinic Type 1 (n=72)	72	100%	0	0%
Family Polyclinic Type 2 (n=73)	71	97%	2	3%
Family Polyclinic Type 2 Branch (n=24)	16	67%	8	33%
Grand Total (n=362)	**350**	**97%**	**12**	**3%**

Table 33: SARA communication tracer indicator scores (I5) by facility type

Communication infrastructure is a strength of Uzbekistan's primary health care system. Despite the declining use of landline telephones, almost all facilities had access to at least one functioning communication system, providing a strong foundation for referrals, emergency coordination, disease surveillance and digital health services. Remaining gaps are concentrated in Family Polyclinic Type 2 Branches. Future investments should focus on ensuring that all facilities, particularly Family Polyclinic Type 2 Branches, have access to at least one reliable communication system. Given the high level of internet availability, strengthening resilient digital connectivity is likely to provide greater long-term benefits than expanding traditional landline infrastructure. Overall, the communication assessment demonstrates a transition from traditional landline telephones towards digital communication systems. While only one-third of facilities retained landline telephones, three-quarters had cellular coverage, nine out of ten had internet access, and 97% met the WHO SARA communication tracer by having at least one functioning communication method. This indicates that communication readiness is no longer constrained by the availability of landlines, but by ensuring resilient and equitable digital connectivity across all facility types.

4.1.6 Internet connectivity (I6)

Reliable internet connectivity is increasingly essential for the delivery of modern primary health care services. It enables health care workers to access electronic medical records, record patient consultations, submit routine health information, communicate with referral facilities, and support telemedicine and remote clinical consultations. In Uzbekistan, internet connectivity is particularly important to support the rollout of the Digital Medical Electronic Database (DMED), which aims to provide a unified electronic health record across all levels of care. Reliable internet access also supports the country's transition towards centralized diagnostic services, allowing facilities to request laboratory investigations, receive electronic test results, and access patient information without relying on paper-based systems. As primary health care becomes increasingly digital, internet connectivity is no longer simply a communication tool but a critical component of service delivery, continuity of care, and health system efficiency. Reliable internet connectivity also facilitates centralized

laboratory networks by enabling electronic test requests, transmission of results, and timely clinical decision-making. As Uzbekistan continues to centralize selected diagnostic services, digital connectivity will become increasingly important to ensure that off-site laboratory testing does not delay diagnosis or treatment.

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



The facility has functioning access to email or the internet on the day of the assessment.

4.1.6.1 Internet connectivity

The SARA survey asked the question "is there access to email or internet within the facility today?"

- ☐ 90% (327/362) had functioning internet on the day of the visit.
- ☐ 10% (35/362) had no internet connectivity.

Internet access exceeded 90% in Family Polyclinics (93%), Multidisciplinary Central Polyclinics (94%) and Family Polyclinic Type 1 facilities (96%), indicating widespread availability of digital communication across the main primary health care facility types. Family Polyclinic Type 2 facilities also demonstrated high levels of connectivity, with 89% reporting functioning internet access. Family Polyclinic Type 2 Branches had substantially lower connectivity, with only 54% (13/24) having internet access on the day of the assessment, while 46% lacked internet connectivity. Overall, only one in ten facilities lacked internet access, although these were concentrated in smaller and lower-level facilities, potentially limiting access to electronic health information systems, digital reporting, telemedicine and communication with higher levels of the health system.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	107	93%	8	7%
Multidisciplinary Central Polyclinic (n=78)	73	94%	5	6%
Family Polyclinic Type 1 (n=72)	69	96%	3	4%
Family Polyclinic Type 2 (n=73)	65	89%	8	11%
Family Polyclinic Type 2 Branch (n=24)	13	54%	11	46%
Grand Total (n=362)	**327**	**90%**	**35**	**10%**

Table 34: Internet connectivity by facility type

Nine out of ten facilities had functioning internet access, providing a strong foundation for electronic health records, digital reporting and telemedicine. The remaining gaps are concentrated in smaller satellite facilities, where improving internet connectivity should remain a priority. The high level of internet connectivity provides a strong platform for continued digital transformation of primary health care. Future investments should focus on extending reliable internet access to the remaining facilities, particularly Family Polyclinic Type 2 Branches, to ensure equitable access to digital health services and information systems.



Figure 36. Computer, Multidisciplinary Central Polyclinic, Angren City, Tashkent Region



Figure 37. Computer, #7 Family Polyclinic Type 2, Termez City, Surkhandarya

4.1.6.2 SARA internet tracer indicator (I6) score

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:

The facility has functioning access to email or the internet on the day of the assessment.

Following the WHO SARA methodology, the overall internet tracer indicator score (I6) was 90% (327/362). Multidisciplinary central polyclinics and family polyclinics achieved the highest performance with 99%, followed by type 1 and type 2 family polyclinics with 93%, while family polyclinics type 2 branch scored significantly lower at 54%. Please note that the full scores for each facility, by type and region can be found in the SARA EXCEL raw data and analysis spreadsheet.

- ☐ **SARA overall privacy tracer indicator score 90% (327/362).**
- ☐ Family Polyclinics scored 93% (107/115).
- ☐ Multi-Profile Central Polyclinics scored 94% (73/78).
- ☐ Family Polyclinic Type 1 scored 96% (69/72).
- ☐ Family Polyclinic Type 2 scored 89% (65/73).
- ☐ Family Polyclinic Type 2 Branch scored 54% (13/24).

The overall SARA tracer indicator scores for internet were as follows:

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	107	93%	8	7%
Multidisciplinary Central Polyclinic (n=78)	73	94%	5	6%
Family Polyclinic Type 1 (n=72)	69	96%	3	4%
Family Polyclinic Type 2 (n=73)	65	89%	8	11%
Family Polyclinic Type 2 Branch (n=24)	13	54%	11	46%
Grand Total (n=362)	**327**	**90%**	**35**	**10%**

Table 35: SARA internet tracer indicator scores (I6) by facility type

Overall, internet connectivity was reasonable, with 90% of facilities having functioning internet access on the day of the assessment. Nevertheless, achieving universal and reliable connectivity should remain a priority. As Uzbekistan continues to implement the Digital Medical Electronic Database (DMED), expand electronic health records, strengthen digital reporting, and centralize diagnostic services, reliable internet access will become increasingly essential for the delivery of primary health care. The absence of internet connectivity in five Multidisciplinary Central Polyclinics is of particular concern given their central role in referrals, diagnostics and coordination of care. However, digital health depends not only on telecommunications infrastructure but also on reliable electricity. Only 19% (70/362) of facilities had a backup generator, while 17% (61/362) experienced frequent power interruptions exceeding two hours per day, leaving many facilities vulnerable to prolonged disruption of internet services, computers and other digital systems during power outages. Strengthening digital health should therefore be accompanied by investments in resilient electrical infrastructure, including backup generators and, where appropriate, solar photovoltaic systems with battery storage, to ensure continuity of health care services.

4.1.6 Emergency transportation (I7)

Access to reliable emergency transportation is essential to ensure that patients requiring urgent or specialist care can be rapidly transferred to higher-level health facilities. Timely referral is particularly important for medical emergencies such as severe trauma, acute cardiovascular events, obstetric complications and neonatal emergencies, where delays can significantly increase morbidity and mortality. Emergency transportation also underpins the effectiveness of referral networks by enabling patients to access specialist services, advanced diagnostics and definitive treatment that are not available at lower-level facilities. As Uzbekistan continues to strengthen its primary health care system and referral pathways, reliable emergency transport remains a critical component of equitable access to health care.

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Facility has a functioning vehicle with fuel that is routinely available that can be used for emergency transportation or access to a vehicle in near proximity that can be used for emergency transportation.

4.1.7.1 Number of functional ambulances onsite

The SARA survey asked the question "number of FUNCTIONAL ambulances (or other vehicles) for emergency transportation of patients to referral facilities?"

- ☐ 66% (238/362) of facilities did not have access to a functional ambulance (or other vehicle).

Two-thirds of surveyed facilities 66% (238/362) did not have a functional ambulance or other emergency transport vehicle on-site, while 34% (124/362) had access to at least one vehicle. Family Polyclinic Type 2 Branches had the poorest transport capacity, with 96% (23/24) reporting no functional emergency vehicle. Family Polyclinic Type 1 (75%) and Family Polyclinic Type 2 (73%) facilities also showed limited on-site emergency transport, with approximately three-quarters lacking a dedicated emergency vehicle. Multidisciplinary Central Polyclinics had the greatest transport capacity, although 63% (49/78) still had no emergency vehicle. Family Polyclinics demonstrated the highest proportion with a single emergency vehicle (47%), while very few facilities of any type maintained multiple emergency vehicles.

Facility Type	0	%	1	%	2	%	3	%
Family Polyclinic (n=115)	59	51%	54	47%	1	1%	1	1%
Multidisciplinary Central Polyclinic (n=78)	49	63%	21	27%	5	6%	3	4%
Family Polyclinic Type 1 (n=72)	54	75%	18	25%	0	0%	0	0%
Family Polyclinic Type 2 (n=73)	53	73%	15	21%	5	7%	0	0%
Family Polyclinic Type 2 Branch (n=24)	23	96%	1	4%	0	0%	0	0%
Grand Total (n=362)	**238**	**66%**	**109**	**30%**	**11**	**3%**	**4**	**1%**

Table 36: Availability of functional ambulances by facility type

- ☐ Family polyclinics: average of 0.5 FUNCTIONAL ambulances.
- ☐ Multidisciplinary central polyclinics: average of 0.5 FUNCTIONAL ambulances.
- ☐ Family polyclinics (type I): average of 0.3 FUNCTIONAL ambulances.
- ☐ Family polyclinics (type II): average of 0.3 FUNCTIONAL ambulances.
- ☐ Family polyclinics (type II branch): average of 0 FUNCTIONAL ambulances.

Primary health care facilities had relatively limited on-site emergency transport capacity, with an average of 0.4 functional ambulances or emergency vehicles per facility. Family Polyclinics and Multidisciplinary Central Polyclinics reported the highest availability, with an average of 0.5 functional emergency vehicles per facility, indicating that approximately one emergency vehicle was available for every two facilities. Family Polyclinic Type 1 and Family Polyclinic Type 2 facilities had lower transport capacity, averaging only 0.3 functional emergency vehicles per facility. Family Polyclinic Type 2 Branches reported no functional emergency vehicles. The findings suggest that lower-level primary health care facilities are heavily dependent on shared ambulance services and referral networks, highlighting the importance of well-coordinated emergency transport systems to ensure timely referral of critically ill patients.

Facility Type	Number of FUNCTIONAL ambulances (or other vehicles) for emergency transportation of patients to referral facilities?
Family Polyclinic (n=115)	0.5
Multidisciplinary Central Polyclinic (n=78)	0.5
Family Polyclinic Type 1 (n=72)	0.3
Family Polyclinic Type 2 (n=73)	0.3
Family Polyclinic Type 2 Branch (n=24)	0.0
Average	**0.4**

Table 37: Average number of functional ambulances by facility type



Figure 38. Ambulance at Nurota Multidisciplinary Central Polyclinic, Navoi



Figure 39. Ambulance at Kasbi Multidisciplinary Central Polyclinic, Kashkadarya

4.1.7.2 Access to ambulance from another facility

The SARA survey asked the question "Does this facility have access to an ambulance or other vehicle for emergency transport for clients that is stationed at another facility or that operates from another facility in near proximity?"

- ☐ 56% (134/238) of facilities with no ambulance reported they did not have access to another vehicle for emergency patient transfer.

Among the 238 facilities without their own ambulance or emergency vehicle, more than half (56%; 134/238) reported that they did not have access to a nearby emergency transport service. This indicates that many facilities lacking on-site transport also lack formal referral transport arrangements. Family Polyclinics demonstrated the poorest access, with 68% (40/59) reporting no access to an emergency vehicle stationed at another facility. Multidisciplinary Central Polyclinics performed better, although 53% (26/49) still reported no access to external emergency transport. Family Polyclinic Type 2 facilities demonstrated the strongest referral arrangements, with 53% (28/53) reporting access to an emergency vehicle from a nearby facility. Family Polyclinic Type 2 Branches remained poorly served, with 61% (14/23) lacking access to external emergency transportation.

Facility Type	No	%	Yes	%
Family Polyclinic (n=115)	40	68%	19	32%
Multidisciplinary Central Polyclinic (n=78)	26	53%	23	47%
Family Polyclinic Type 1 (n=72)	29	54%	25	46%
Family Polyclinic Type 2 (n=73)	25	47%	28	53%
Family Polyclinic Type 2 Branch (n=24)	14	61%	9	39%
Grand Total (n=362)	**134**	**56%**	**104**	**44%**

Table 38: Access to ambulance from other facilities by facility type

Many facilities without their own emergency vehicle also lacked access to a nearby ambulance service, highlighting potential weaknesses in emergency referral arrangements. This suggests that reliance on shared ambulance services is not always supported by formal transport networks, particularly for Family Polyclinics and Family Polyclinic Type 2 Branches. MoH should consider reinforcing ambulance

arrangements. Facilities that do not maintain their own ambulance should have formal referral arrangements guaranteeing timely access to emergency transport. Strengthening shared ambulance networks, clearly defining referral pathways, and ensuring emergency vehicles are strategically located could substantially improve access to higher-level care without requiring every primary health care facility to own an ambulance.

4.1.7.3 Fuel for ambulances

The SARA survey asked the question "Is fuel for the ambulance or other emergency vehicle available today?" if the facility had their own ambulance or access to a shared ambulance.

- ☐ 66% (151/228) of facilities with ambulances (or access to an ambulance) reported there was fuel available.

Among facilities with access to an ambulance or emergency transport vehicle, only 66% (151/228) reported that fuel was available on the day of the assessment, while 34% (77/228) had no fuel available, potentially limiting their ability to respond to critical referral emergencies. Family Polyclinics demonstrated the highest level of operational readiness, with 73% reporting fuel availability, followed by Multidisciplinary Central Polyclinics (69%). Fuel availability was lower in Family Polyclinic Type 1 (63%) and Family Polyclinic Type 2 (60%) facilities, indicating that approximately one-third to two-fifths of emergency vehicles could not be immediately deployed. Family Polyclinic Type 2 Branches recorded the lowest operational readiness, with only 40% (4/10) reporting fuel availability, while 60% lacked fuel despite having access to an emergency vehicle.

The findings indicate that access to emergency transport does not necessarily translate into operational readiness, as one-third of facilities with an ambulance or referral vehicle were unable to confirm that fuel was available at the time of the assessment.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	55	73%	20	27%
Multidisciplinary Central Polyclinic (n=78)	27	63%	16	37%
Family Polyclinic Type 1 (n=72)	29	60%	19	40%
Family Polyclinic Type 2 (n=73)	4	40%	6	60%
Family Polyclinic Type 2 Branch (n=24)	36	69%	16	31%
Grand Total (n=362)	**151**	**66%**	**77**	**34%**

Table 39: Availability of fuel for ambulances by facility type

Operational readiness of emergency transport remains a concern. While many facilities reported access to an ambulance or emergency vehicle, one in three could not confirm fuel availability, potentially delaying emergency referrals when rapid patient transfer is required. Emergency transport readiness should be assessed not only by the availability of ambulances but also by their operational status, including fuel availability, maintenance and driver availability. Establishing reliable systems for vehicle maintenance and fuel supply should form part of strengthening emergency referral services.

4.1.7.4 SARA emergency transportation tracer indicator (I7) score

Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Facility has a functioning vehicle with fuel that is routinely available that can be used for emergency transportation or access to a vehicle in near proximity that can be used for emergency transportation.

Following the WHO SARA methodology, the overall emergency transportation tracer indicator score (I7) was 42% (151/362) meaning they had access to a functional ambulance or other emergency vehicle, either on-site or through a nearby facility, with fuel available on the day of the assessment. Most facilities 58% (211/362) did not meet the tracer indicator, indicating that emergency transport arrangements were either unavailable or not operational at the time of the survey. Family Polyclinics (48%) and Multidisciplinary Central Polyclinics (46%) achieved the highest readiness scores, although fewer than half met the WHO SARA standard. Readiness was lower in Family Polyclinic Type 1 (38%) and Family Polyclinic Type 2 (40%) facilities, where approximately three in five facilities lacked operational emergency referral transport. Family Polyclinic Type 2 Branches demonstrated the lowest level of readiness, with only 17% (4/24) meeting the SARA tracer, while 83% lacked operational emergency transport. Please note that the full scores for each facility, by type and region can be found in the SARA EXCEL raw data and analysis spreadsheet.

- ☐ **SARA overall emergency transportation indicator score 42% (151/362).**
- ☐ Family Polyclinics scored 48% (55/115).
- ☐ Multi-Profile Central Polyclinics scored 46% (36/78).
- ☐ Family Polyclinic Type 1 scored 38% (27/72).
- ☐ Family Polyclinic Type 2 scored 40% (29/73).
- ☐ Family Polyclinic Type 2 Branch scored 17% (4/24).

The overall SARA tracer indicator scores for emergency transportation were as follows:

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	55	48%	60	52%
Multidisciplinary Central Polyclinic (n=78)	36	46%	42	54%
Family Polyclinic Type 1 (n=72)	27	38%	45	63%
Family Polyclinic Type 2 (n=73)	29	40%	44	60%
Family Polyclinic Type 2 Branch (n=24)	4	17%	20	83%
Grand Total (n=362)	**151**	**42%**	**211**	**58%**

Table 40: SARA emergency transport tracer indicator scores (I7) by facility type

Overall, the emergency referral transport assessment demonstrates that weaknesses exist throughout the referral chain. Two-thirds of facilities had no on-site emergency vehicle, more than half of these lacked access to a nearby shared vehicle, and one-third of facilities with access to emergency transport reported that fuel was unavailable. Consequently, only 42% of facilities met the WHO SARA emergency

transport tracer. These findings suggest that strengthening emergency referral systems should focus on the reliability of the entire transport network rather than simply increasing the number of ambulances. Formal referral agreements strategically located shared ambulance services, sustainable fuel supplies and preventive vehicle maintenance are all required to ensure timely emergency referral.

4.1.8 Basic amenities domain final score (DO1)

The basic amenities (DO1) percentage score is calculated by dividing the sum of the seven tracer indicators by 7.

Formula:

$$\textbf{D01} = \frac{I1 + I2 + I3 + I4 + I5 + I6 + I7}{7} * 100\%$$

where:
I1 = Power Continuity
I2 = Improved Water
I3 = Consultation Room Privacy
I4 = Sanitation
I5 = Communication
I6 = Internet
I7 = Referral Ambulance

The final scores were as follows:

Basic Amenities (DO1)	National Level	Family Polyclinic	Multidisciplinary Central Polyclinic	Family Polyclinic Type 1	Family Polyclinic Type 2	Family Polyclinic Type 2 Branch
	(n = 362)	(n = 115)	(n = 78)	(n = 72)	(n = 73)	(n = 24)
I1) Power continuity	83%	89%	97%	69%	78%	67%
I2) Improved water	95%	99%	100%	94%	96%	58%
I3) Privacy	37%	40%	56%	19%	37%	13%
I4) Sanitation	94%	99%	99%	93%	93%	54%
I5) Communication	97%	98%	100%	100%	97%	67%
I6) Internet	90%	93%	94%	96%	89%	54%
I7) Referral ambulance	42%	48%	46%	38%	40%	17%
Average Score DO1	**77%**	**81%**	**85%**	**73%**	**76%**	**47%**

Table 41: SARA basic amenities tracer indicator scores (DO1) by facility type

The national Basic Amenities (DO1) score was 77%, indicating that most primary health care facilities possess the essential infrastructure required to support routine service delivery. The assessment identified several important strengths. Communication (97%), improved water (95%), sanitation (94%), internet connectivity (90%), and power continuity (83%) were generally well established across the primary health care system, providing a strong foundation for service delivery and the continued digital transformation of health care. However, two tracer indicators substantially reduced the overall Basic Amenities score. Consultation room privacy (37%) was the lowest-scoring infrastructure indicator, suggesting that many facilities do not provide adequate visual and auditory privacy for patient consultations. Emergency referral transportation (42%) also scored poorly, highlighting important weaknesses in emergency referral capacity, including limited ambulance availability, inadequate referral arrangements, and poor operational readiness.

Important differences were observed between facility types. Multidisciplinary Central Polyclinics achieved the highest DO1 score (85%), reflecting consistently strong infrastructure across most domains. Family Polyclinics (81%) also performed well. In contrast, Family Polyclinic Type 1 (73%) and Family Polyclinic Type 2 (76%) scored lower, primarily due to reduced power reliability, limited consultation privacy, and weaker emergency transport arrangements. Family Polyclinic Type 2 Branches recorded the lowest score (47%), with particularly poor performance in improved water supply, sanitation, internet connectivity, communication, consultation privacy and emergency referral transportation, demonstrating substantial infrastructure deficits.

Overall, the findings indicate that while Uzbekistan has made significant progress in providing the basic infrastructure required for primary health care, future investments should prioritise strengthening consultation privacy, emergency referral systems, and the infrastructure of lower-level Family Polyclinic Type 2 Branches. Maintaining reliable electricity and internet connectivity will also be increasingly important as the Ministry of Health continues to expand digital health services through the Digital Medical Electronic Database (DMED), electronic health records and centralized diagnostic services.

4.2 Basic equipment (DO2)

Basic equipment forms the foundation of safe and effective primary health care. These essential clinical tools enable health care workers to perform routine patient assessments, monitor vital signs, identify, monitor and manage common health conditions, and support timely diagnosis, treatment and referral. High availability of basic equipment is therefore a key indicator of facility readiness to deliver quality health services.

The DO2 Basic Equipment domain assesses the availability of six tracer indicators representing the minimum basic equipment required to support routine primary health care. The DO2 percentage score is calculated by dividing the number of tracer indicators present on the day of the visit by 6.

Formula:

$$\textbf{DO2} = \frac{E1 + E2 + E3 + E4 + E5 + E6}{6} * 100\%$$

where:
E1 = Adult Scale
E2 = Child Scale
E3 = Thermometer
E4 = Stethoscope
E5 = Blood Pressure Apparatus
E6 = Examination Light

The list of tracer indicators is taken from the publication *"Service Availability and Readiness Assessment (SARA) | Reference Manual, Version 2.2"* (WHO, 2015).

4.2.1 Adult scales (E1)

An adult weighing scale is essential for assessing nutritional status, monitoring weight changes, calculating body mass index (BMI), determining medication dosages, and supporting the diagnosis and management of conditions such as obesity, malnutrition and chronic diseases. Under the WHO SARA methodology, a facility is awarded one point if it has at least one functional adult scale on the day of the visit. The SARA survey asked each facility to document the number of functional, non-functional, and needed adult weighing scales.

- ☐ 94% (340/362) of facilities had functional adult weighing scales.

The assessment found that adult weighing scales were available in 94% (340/362) of surveyed facilities, indicating that most primary health care facilities possess the equipment required to routinely assess adult nutritional status, monitor weight, and support clinical management. Family Polyclinics (98%) and Family Polyclinic Type 2 facilities (97%) demonstrated the highest availability of functional adult scales, followed closely by Multidisciplinary Central Polyclinics (96%). Family Polyclinic Type 1 facilities reported slightly lower availability (90%), although nine out of ten facilities still had a functional adult scale. Family Polyclinic Type 2 Branches recorded the lowest availability (67%), with one-third (33%) lacking a functional adult scale, highlighting an important equipment gap at the lowest level of the primary health care system.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	113	98%	2	2%
Multidisciplinary Central Polyclinic (n=78)	75	96%	3	4%
Family Polyclinic Type 1 (n=72)	65	90%	7	10%
Family Polyclinic Type 2 (n=73)	71	97%	2	3%
Family Polyclinic Type 2 Branch (n=24)	16	67%	8	33%
Grand Total (n=362)	**340**	**94%**	**22**	**6%**

Table 42: Facilities with at least one functional adult scale by facility type

Availability of adult weighing scales was consistently high across most primary health care facilities, demonstrating that this essential piece of clinical equipment is widely available for routine patient assessment. The principal gap was observed in Family Polyclinic Type 2 Branches, where one-third of facilities lacked a functional adult scale, potentially limiting routine assessment of nutritional status and chronic disease management. Maintaining universal access to functional adult weighing scales should remain a priority, particularly in lower-level branch facilities where relatively small investments could eliminate one of the remaining gaps in basic clinical equipment.

- ☐ Average 6 FUNCTIONAL per facility.
- ☐ Average 1 NON-FUNCTIONAL per facility.
- ☐ Average 4 ADDITIONAL NEEDED per facility.

The assessment found that surveyed facilities had an average of six functional adult weighing scales, indicating that most facilities possessed multiple scales to support routine clinical services. On average, one adult weighing scale per facility was non-functional, suggesting that while equipment availability was generally high, maintenance and replacement remain important to sustain service readiness. Photos collected on the Kobo platform showed a wide range of adult scale types varying from simple mechanical scales to battery powered bathroom scales, and mains electric scales with integrated height boards. It was informally observed that the main reason for faulty equipment was that batteries had not been replaced, or the unit had an electrical fault.

Facilities reported needing an average of four additional adult weighing scales, indicating that existing equipment was often insufficient to meet workload or service delivery requirements despite high overall availability. Multidisciplinary Central Polyclinics had the largest equipment requirements, with an average of 10 functional scales, 3 non-functional scales, and 10 additional scales needed per facility. This likely reflects their larger size, broader range of services and higher patient volumes rather than poorer equipment provision. Family Polyclinic Type 2 Branches operated with an average of only one functional adult weighing scale and reported needing one additional scale, reflecting their smaller size and more limited-service capacity.

Facility Type	Average of Functional	Average of Non-Functional	Average of Needed
Family Polyclinic (n=115)	6	1	3
Multidisciplinary Central Polyclinic (n=78)	10	3	10
Family Polyclinic Type 1 (n=72)	3	0	2
Family Polyclinic Type 2 (n=73)	7	1	4
Family Polyclinic Type 2 Branch (n=24)	1	0	1
Grand Total (n=362)	**6**	**1**	**4**

Table 43: Average numbers of adult scales available per facility, by facility type



Figure 40. Bathroom Battery Powered Scales, Gijduvan District Family Polyclinic Type 2, Bukhara



Figure 41. Adult Electric Scales, Family Polyclinic #49 Muzrabot, Surkhandarya



Figure 42. Adult Electric Scales Karmana Multidisciplinary Central Polyclinic, Navoi



Figure 43. Adult Mechanical Scales, Family Polyclinic Parkent District, Tashkent Region



Figure 44. Bathroom Battery Powered Scales, Beshariq Multidisciplinary Central Polyclinic, Fergana



Figure 45. Adult Electric Scales, Family Polyclinic #1, Syrdaryo District, Syrdaryo

4.2.2 Child scales (E2)

Infant weighing scales are critical for monitoring growth and development, assessing nutritional status, identifying undernutrition or growth faltering, and calculating accurate medication dosages for infants and young children. Under the WHO SARA methodology, a facility is awarded one point if it has at least one functional infant scale, with 100g graduation, on the day of the visit. The SARA survey asked each facility to document the number of functional, non-functional, and needed infant weighing scales.

- ☐ 77% (277/362) of facilities had functional infant weighing scales with 100g graduation.

The assessment found that just over three-quarters of surveyed facilities 77% (277/362) had at least one functional infant weighing scale, meaning that almost one in four facilities (23%) lacked this essential

piece of equipment for monitoring infant growth and development. Family Polyclinic Type 2 facilities recorded the highest availability (85%), followed by Family Polyclinic Type 1 (79%) and Family Polyclinics (78%). Multidisciplinary Central Polyclinics demonstrated slightly lower availability (72%), with more than one-quarter of facilities lacking a functional infant scale. Family Polyclinic Type 2 Branches had the lowest availability, with only 50% possessing a functional infant scale, indicating that half of these facilities were unable to routinely weigh infants.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	90	78%	25	22%
Multidisciplinary Central Polyclinic (n=78)	56	72%	22	28%
Family Polyclinic Type 1 (n=72)	57	79%	15	21%
Family Polyclinic Type 2 (n=73)	62	85%	11	15%
Family Polyclinic Type 2 Branch (n=24)	12	50%	12	50%
Grand Total (n=362)	**277**	**77%**	**85**	**23%**

Table 44: Facilities with at least one functional infant scale (100g graduation) by facility type

Availability of infant weighing scales was substantially lower than adult weighing scales (77% versus 94%), indicating a significant gap in equipment needed to monitor infant growth, assess nutritional status and support child health services. The greatest deficiencies were observed in Family Polyclinic Type 2 Branches, where only half of facilities had a functional infant scale. Improving access to functional infant weighing scales should be prioritised, particularly in lower-level facilities providing maternal and child health services. Ensuring universal availability would strengthen routine growth monitoring, nutritional assessment and the early detection of growth faltering in infants.

- ☐ Average 6 FUNCTIONAL per facility.
- ☐ Average 1 NON-FUNCTIONAL per facility.
- ☐ Average 5 ADDITIONAL NEEDED per facility.

The assessment found that surveyed facilities had an average of six functional infant weighing scales per facility, indicating that facilities with infant scales generally maintained multiple units to support routine maternal and child health services. On average, one infant weighing scale per facility was non-functional, suggesting that regular equipment maintenance and replacement are required to sustain service readiness. Photos collected on the Kobo platform showed a wide range of infant scale types including mechanical scales, simple hanging mechanical and battery powered “luggage” type scales, and mains electric scales with integrated length boards. It was informally observed that the main reason for faulty equipment was that batteries had not been replaced, or the unit had an electrical fault.

Facilities reported needing an average of five additional infant weighing scales, indicating that the existing number of scales was frequently insufficient to meet service demand, despite relatively good equipment availability in many facilities.

Multidisciplinary Central Polyclinics reported the greatest equipment requirements, with an average of seven functional scales, three non-functional scales, and eleven additional scales needed per facility. This likely reflects their larger patient volumes and broader maternal and child health service provision rather

than poorer equipment availability. Family Polyclinic Type 2 Branches operated with an average of only one functional infant weighing scale and reported requiring one additional scale, reflecting their smaller size but limited equipment capacity.

Although facilities possessed an average of six functional infant weighing scales, they reported requiring an additional five scales per facility on average. Together with the finding that only 77% of facilities had at least one functional infant scale, this suggests that both equipment availability and equipment quantity remain important constraints for delivering comprehensive child health services.

Facility Type	Average of Functional	Average of Non-Functional	Average of Needed
Family Polyclinic (n=115)	6	1	4
Multidisciplinary Central Polyclinic (n=78)	7	3	11
Family Polyclinic Type 1 (n=72)	4	0	2
Family Polyclinic Type 2 (n=73)	8	1	4
Family Polyclinic Type 2 Branch (n=24)	1	0	1
Grand Total (n=362)	**6**	**1**	**5**

Table 45: Average numbers of infant scales available per facility by facility type



Figure 46. Electric Infant Scale, Beshariq Multidisciplinary Central Polyclinic, Fergana



Figure 47. Electric Infant Scale with Measuring Board, Family Polyclinic #7 Kokand, Fergana



Figure 48. Hanging Infant Scale, Family Polyclinic #8, Bukhara City



Figure 49. Mechanical Infant Scale, Mingbuloq Multidisciplinary Central Polyclinic, Namangan



Figure 50. Mechanical Hanging Infant Scale, Qarshi Multidisciplinary Central Polyclinic, Kashkadarya



Figure 51. Battery Powered Hanging Infant Scales, Dehqonobod Multidisciplinary Central Polyclinic, Kashkadarya

4.2.3 Thermometers (E3)

Thermometers are a fundamental diagnostic tool for detecting levels of fever and hypothermia, supporting the early identification of infectious diseases and other acute medical conditions, while enabling appropriate clinical management and referral. Under the WHO SARA methodology, a facility is awarded one point if it has at least one functional thermometer on the day of the visit. The SARA survey asked each facility to document the number of functional, non-functional, and needed thermometers.

- ☐ 96% (349/362) of facilities had at least one functioning thermometer.

The assessment found that thermometers were almost universally available, with 349 of 362 facilities (96%) possessing at least one functional thermometer, making this one of the strongest-performing basic equipment indicators. Family Polyclinics demonstrated the highest availability, with 113 of 115 facilities (98%) reporting a functional thermometer. Availability was consistently high across all other facility types, including Family Polyclinic Type 1 (97%), Family Polyclinic Type 2 (96%), and Multidisciplinary Central Polyclinics (95%). Family Polyclinic Type 2 Branches recorded the lowest availability (92%), although more than nine in ten facilities still had a functional thermometer.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	113	98%	2	2%
Multidisciplinary Central Polyclinic (n=78)	74	95%	4	5%
Family Polyclinic Type 1 (n=72)	70	97%	2	3%
Family Polyclinic Type 2 (n=73)	70	96%	3	4%
Family Polyclinic Type 2 Branch (n=24)	22	92%	2	8%
Grand Total (n=362)	**349**	**96%**	**13**	**96%**

Table 46: Facilities with at least one functional thermometer by facility type

Functional thermometers were available in almost all surveyed facilities, indicating that primary health care facilities are generally well equipped to measure body temperature as part of routine patient assessment and the detection of infectious and other acute illnesses. Equipment gaps were small and largely confined

to a limited number of lower-level facilities. Maintaining universal availability of functional thermometers should remain a priority, as they are inexpensive, essential diagnostic tools used in virtually every primary health care consultation. Targeted replacement of missing or non-functional thermometers in the small number of affected facilities would enable near-universal coverage nationally.

- ☐ Average 25 FUNCTIONAL per facility.
- ☐ Average 2 NON-FUNCTIONAL per facility.
- ☐ Average 15 ADDITIONAL NEEDED per facility.

The assessment found that surveyed facilities had an average of 25 functional thermometers per facility, indicating that thermometers were widely available and distributed across multiple consultation rooms and clinical areas. On average, two thermometers per facility were non-functional, suggesting that equipment maintenance requirements were relatively low compared with the number of functioning devices.

The assessment identified a mixture of digital, infrared («non-contact») and traditional mercury thermometers across surveyed facilities. The most common reasons for non-functional digital thermometers were depleted batteries and electrical faults, suggesting that relatively minor maintenance and replacement programmes could substantially improve equipment availability. Many mercury thermometers were also observed which have risks associated with mercury exposure and environmental contamination following breakage or disposal. Under the Minamata Convention on Mercury, adopted in 2013 and entered into force in 2017, the global manufacture, import and export of many mercury-added products, including most mercury thermometers, has been phased out, with implementation dates around 2020 (subject to exemptions and national legislation). Uzbekistan should implement a gradual replacement of mercury thermometers with gallium alloy or digital alternatives to improve patient and staff safety, reduce environmental risks, and simplify equipment maintenance. Ensuring an adequate supply of replacement batteries would also address one of the principal causes of non-functional digital thermometers.

Facilities reported needing an average of 15 additional thermometers, indicating that, despite high overall availability, the number of thermometers was often insufficient to fully meet operational requirements. Multidisciplinary Central Polyclinics possessed the largest number of thermometers, with an average of 46 functional and 5 non-functional thermometers per facility, while also reporting the greatest additional need (26 thermometers). This likely reflects their larger size, higher patient volumes and greater number of consultation and treatment rooms. Family Polyclinic Type 2 Branches maintained an average of only two functional thermometers and reported needing three additional units, consistent with their smaller scale of operation.

Thermometers were almost universally available across surveyed facilities, and facilities generally possessed multiple units. However, the reported requirement for an average of 15 additional thermometers per facility suggests that existing equipment was often insufficient to equip all consultation rooms and clinical service areas simultaneously. Future procurement should focus not only on replacing non-functional thermometers but also on ensuring that sufficient numbers are available to equip all consultation and treatment areas. Procurement targets should be based on facility size, staffing levels and service workload rather than providing a fixed number of thermometers per facility.

Facility Type	Average of Functional	Average of Non-Functional	Average of Needed
Family Polyclinic (n=115)	24	2	14
Multidisciplinary Central Polyclinic (n=78)	46	5	26
Family Polyclinic Type 1 (n=72)	15	3	11
Family Polyclinic Type 2 (n=73)	23	1	14
Family Polyclinic Type 2 Branch (n=24)	2	0	3
Grand Total (n=362)	**25**	**2**	**15**

Table 47: Average numbers of thermometers available per facility by facility type



Figure 52. Digital Thermometer, Denov Family Polyclinic Type 2 Branch, Surkhandarya



Figure 53. Mixture of Digital and Mercury Thermometers, Family Polyclinic #44 G'uzor district, Kashkadarya



Figure 54. Mercury Thermometers, Kagan Multidisciplinary Central Polyclinic, Bukhara



Figure 55. Mercury Thermometers, #12 Family Polyclinic, Vobkent, Bukhara

4.2.4 Stethoscopes (E4)

A stethoscope is an essential clinical instrument used to assess heart, lung and bowel sounds, assisting health care workers in diagnosing cardiovascular, respiratory and other common medical conditions during routine patient examinations. The SARA survey asked each facility to document the number of functional, non-functional, and needed stethoscopes.

- ☐ 86% (313/362) of facilities had at least one functioning stethoscope.

The assessment found that a functional stethoscope was available in 86% (313/362) of surveyed facilities, indicating that most primary health care facilities possessed this essential clinical examination tool. Family Polyclinics demonstrated the highest availability (95%), closely followed by Multidisciplinary Central Polyclinics (92%). Availability was lower in Family Polyclinic Type 2 facilities (88%) and Family Polyclinic Type 1 facilities (82%), with approximately one in five Type 1 facilities lacking a functional stethoscope. Family Polyclinic Type 2 Branches recorded the lowest availability, with only 34% (9/24) possessing a functional stethoscope, meaning that two-thirds (66%) lacked this essential piece of equipment.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	109	95%	6	5%
Multidisciplinary Central Polyclinic (n=78)	72	92%	6	8%
Family Polyclinic Type 1 (n=72)	59	82%	13	18%
Family Polyclinic Type 2 (n=73)	64	88%	9	12%
Family Polyclinic Type 2 Branch (n=24)	9	34%	15	66%
Grand Total (n=362)	**313**	**86%**	**49**	**14%**

Table 48: Facilities with at least one functional stethoscope by facility type

Although functional stethoscopes were available in most surveyed facilities, one in seven facilities nationally lacked this fundamental diagnostic tool. The most significant deficiencies were observed in Family Polyclinic Type 2 Branches, where the absence of stethoscopes would limit routine clinical assessment and the diagnosis of common cardiovascular and respiratory conditions. Universal access to functional stethoscopes should be prioritised, particularly in lower-level facilities. As one of the most fundamental and relatively inexpensive clinical instruments, ensuring that every consultation area is equipped with a functional stethoscope would strengthen the quality of routine patient assessment and support earlier diagnosis of common health conditions.

- ☐ Average 10 FUNCTIONAL per facility.
- ☐ Average 1 NON-FUNCTIONAL per facility.
- ☐ Average 6 ADDITIONAL NEEDED per facility.

Surveyed facilities had an average of 10 functional stethoscopes, indicating that most facilities were equipped with multiple devices to support clinical consultations. Only one non-functional stethoscope was reported on average per facility, suggesting that equipment maintenance issues were relatively limited. Facilities reported needing an average of six additional stethoscopes, indicating that while stethoscopes were generally available, existing numbers were often insufficient to equip all consultation rooms and

clinical staff. Multidisciplinary Central Polyclinics possessed the largest number of stethoscopes, averaging 19 functional and 2 non-functional units, while also reporting the greatest additional requirement (10 stethoscopes). This is consistent with their larger size, broader range of services and higher staffing levels. Family Polyclinic Type 2 Branches averaged only two functional stethoscopes per facility and required one additional unit, reflecting their smaller workforce and service capacity.

Most facilities possessed multiple functional stethoscopes, enabling routine clinical assessment. However, the reported need for an average of six additional stethoscopes per facility suggests that many facilities lacked enough to fully equip all consultation rooms or health care providers. The greatest demand was observed in larger multidisciplinary facilities, where equipment requirements are naturally higher because of greater patient volumes and staffing levels. Procurement efforts should focus on ensuring an adequate number of stethoscopes for each facility based on workforce size and service delivery needs, rather than simply providing a minimum number per facility. Given their low cost and central role in diagnosing cardiovascular and respiratory conditions, expanding access to stethoscopes represents a cost-effective investment in improving the quality of primary health care.

Photographic review of equipment captured through the Kobo data collection tool suggested that most facilities continued to use traditional wooden acoustic stethoscopes. While these remain functional for routine clinical assessment, gradual replacement with modern stethoscopes with stainless steel or aluminium chest pieces generally provide better acoustic performance and are more durable and easier to disinfect. Equipment modernization programmes should therefore consider both increasing the number of available stethoscopes and progressively replacing older models.

Facility Type	Average of Functional	Average of Non-Functional	Average of Needed
Family Polyclinic (n=115)	8	1	6
Multidisciplinary Central Polyclinic (n=78)	19	2	10
Family Polyclinic Type 1 (n=72)	7	0	2
Family Polyclinic Type 2 (n=73)	10	0	6
Family Polyclinic Type 2 Branch (n=24)	2	0	1
Grand Total (n=362)	**10**	**1**	**6**

Table 49: Average numbers of stethoscopes available per facility by facility type



Figure 56. Wooden Stethoscope, Kagan Multidisciplinary Central Polyclinic, Bukhara



Figure 57. Wooden Stethoscope, Family Polyclinic #16, Ishtikhan District, Samarkand



Figure 58. Wooden Stethoscope, Gijduvon Family Polyclinic #7, Bukhara



Figure 59. Mixture of Wooden and Stainless Steel Stethoscope, #12 Family Polyclinic, Kitab, Kashkadarya

4.2.5 Blood pressure apparatus (E5)

A blood pressure apparatus is essential for the detection, diagnosis and monitoring of hypertension, one of the leading risk factors for cardiovascular disease, stroke and kidney disease. It is also critical for identifying hypotension and monitoring acutely ill patients. The SARA survey asked each facility to document the number of functional, non-functional, and needed blood pressure monitoring devices.

- ☐ 94% (339/362) of facilities had at least one functioning blood pressure apparatus.

The assessment found that a functional blood pressure apparatus was available in 94% (339/362) of surveyed facilities, indicating that this essential diagnostic instrument was almost universally available across Uzbekistan's primary health care system. Availability was consistently high across all main facility types, ranging from 94% to 96%, with Family Polyclinics recording the highest availability (96%). Family Polyclinic Type 2 Branches had the lowest availability (79%), with one in five branches lacking a functional blood pressure apparatus, representing the principal equipment gap for this indicator. Only 6% of facilities nationally lacked a functional blood pressure apparatus, suggesting that the capacity to routinely screen and monitor hypertension is well established in most primary health care facilities.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	110	96%	5	4%
Multidisciplinary Central Polyclinic (n=78)	73	94%	5	6%
Family Polyclinic Type 1 (n=72)	68	94%	4	6%
Family Polyclinic Type 2 (n=73)	69	95%	4	5%
Family Polyclinic Type 2 Branch (n=24)	19	79%	5	21%
Grand Total (n=362)	**339**	**94%**	**23**	**6%**

Table 50: Facilities with at least one functional blood pressure apparatus

Blood pressure apparatuses were available in almost all surveyed facilities, demonstrating strong readiness to support the screening, diagnosis and monitoring of hypertension and other cardiovascular conditions. Equipment shortages were limited nationally but remained concentrated in Family Polyclinic Type 2 Branches, where the absence of this essential diagnostic tool may restrict routine cardiovascular

assessment. Maintaining universal access to functional blood pressure apparatuses should remain a priority. Targeted procurement should focus on lower-level branch facilities to achieve full national coverage, while routine calibration, maintenance and replacement programmes should ensure the continued accuracy and reliability of blood pressure measurements.

- ☐ Average 21 FUNCTIONAL per facility.
- ☐ Average 4 NON-FUNCTIONAL per facility.
- ☐ Average 13 ADDITIONAL NEEDED per facility.

Surveyed facilities possessed an average of 21 functional blood pressure apparatuses, indicating that most facilities were equipped with multiple devices to support routine patient assessment across consultation rooms. Facilities reported an average of four non-functional blood pressure apparatuses per facility, the highest number of non-functional items observed among the basic equipment indicators assessed to date. This suggests that maintenance, calibration or replacement of ageing equipment may require greater attention. Facilities estimated they required an average of 13 additional blood pressure apparatuses, indicating that, despite high overall availability, existing numbers were often insufficient to fully meet operational requirements. Multidisciplinary Central Polyclinics had the largest inventory, averaging 36 functional and 8 non-functional blood pressure apparatuses, while also reporting the greatest additional requirement (28 units). This reflects their larger workforce, multiple consultation rooms and higher patient volumes. Family Polyclinic Type 2 Branches averaged only two functional blood pressure apparatuses and required one additional unit, consistent with their smaller size and staffing levels.

Blood pressure apparatuses were widely available and facilities generally possessed multiple devices. However, the relatively high number of non-functional units and the reported need for an average of 13 additional devices per facility suggest that procurement should focus not only on replacing ageing equipment but also on ensuring sufficient numbers are available to equip all consultation rooms and clinical staff. Future procurement programmes should prioritise replacement of non-functional blood pressure apparatuses while expanding the number of available devices in line with facility workload and staffing levels. Regular maintenance and calibration programmes should also be strengthened to ensure accurate blood pressure measurement, which is essential for the early detection and management of hypertension and cardiovascular disease.

Facility Type	Average of Functional	Average of Non-Functional	Average of Needed
Family Polyclinic (n=115)	21	2	10
Multidisciplinary Central Polyclinic (n=78)	36	8	28
Family Polyclinic Type 1 (n=72)	9	2	6
Family Polyclinic Type 2 (n=73)	23	3	11
Family Polyclinic Type 2 Branch (n=24)	2	0	1
Grand Total (n=362)	**21**	**4**	**13**

Table 51: Average numbers of blood pressure apparatus available per facility by facility type



Figure 60. Blood Pressure Apparatus, Family Polyclinic Type 2, Syrdarya District, Syrdarya



Figure 61. Blood Pressure Apparatus, Family Polyclinic #62, Uchtepa, Tashkent City



Figure 62. Blood Pressure Apparatus, Multidisciplinary Central Polyclinic, Fergana City



Figure 63. Blood Pressure Apparatus, Multidisciplinary Central Polyclinic, Karakul District, Bukhara



Figure 64. Blood Pressure Apparatus, Family Polyclinic #1, Bekabad City, Tashkent Region



Figure 65. Blood Pressure Apparatus, #10 Family Polyclinic, Kattakurgan, Samarkand

4.2.6 Basic equipment domain final score (DO2)

The DO2 Basic Equipment domain assesses the availability of six tracer indicators representing the minimum basic equipment required to support routine primary health care. The DO2 percentage score is calculated by dividing the number of tracer indicators present on the day of the visit by 6.

Formula:

$$\textbf{DO2} = \frac{E1 + E2 + E3 + E4 + E5 + E6}{6} * 100\%$$

where:
E1 = Adult Scale
E2 = Child Scale
E3 = Thermometer
E4 = Stethoscope
E5 = Blood Pressure Apparatus
E6 = Light Source

The final scores were as follows:

Basic Equipment (DO2)	National Level	Family Polyclinic	Multidisciplinary Central Polyclinic	Family Polyclinic Type 1	Family Polyclinic Type 2	Family Polyclinic Type 2 Branch
	(n = 362)	(n = 115)	(n = 78)	(n = 72)	(n = 73)	(n = 24)
E1) Adult scales	94%	98%	96%	90%	97%	67%
E2) Infant Scales	84%	94%	85%	82%	82%	50%
E3) Thermometers	96%	98%	95%	97%	96%	92%
E4) Stethoscopes	86%	95%	92%	82%	88%	38%
E5) Blood Pressure	94%	96%	94%	94%	95%	79%
E6) Light Source	100%	100%	100%	100%	100%	100%
Average Score DO2	**92%**	**97%**	**94%**	**91%**	**93%**	**71%**

Table 52: SARA basic equipment tracer indicator scores (DO2) by facility type

The national Basic Equipment (DO2) score was 92%, indicating that the minimum equipment required for routine primary health care was widely available across surveyed facilities. This was one of the strongest-performing General Service Readiness domains. All main facility types demonstrated high levels of readiness, with DO2 scores ranging from 91% to 97%, indicating that basic equipment availability was consistently strong throughout the primary health care system.

Family Polyclinics achieved the highest readiness (97%), followed by Multidisciplinary Central Polyclinics (94%) and Family Polyclinic Type 2 facilities (93%). Family Polyclinic Type 1 facilities also demonstrated strong performance (91%). Family Polyclinic Type 2 Branches recorded substantially lower readiness (71%), reflecting persistent equipment shortages in smaller, lower-level facilities. Five of the six tracer indicators achieved national availability of at least 86%, with light sources (100%), thermometers (96%), blood pressure apparatuses (94%), and adult scales (94%) demonstrating near-universal availability. Stethoscopes (86%) and infant weighing scales (84%) represented the principal equipment gaps nationally, while Family Polyclinic Type 2 Branches consistently recorded the lowest availability across most indicators.

The findings demonstrate that Uzbekistan's primary health care facilities are generally well equipped to provide routine clinical services, with a national Basic Equipment readiness score of 92%. Essential equipment for measuring vital signs - including thermometers, blood pressure apparatuses and adult weighing scales - was available in almost all facilities. Remaining deficiencies were concentrated in infant weighing scales and stethoscopes, particularly in lower-level branch facilities, indicating that future investment should focus on targeted procurement rather than broad national equipment replacement. Maintaining the high level of basic equipment readiness should remain a priority. Future investment should prioritise equipping Family Polyclinic Type 2 Branches, replace ageing or non-functional equipment, and ensuring enough essential equipment are available to equip all consultation rooms. Progressive replacement of older equipment, such as mercury thermometers and traditional wooden stethoscopes, would further modernise primary health care services while improving safety and quality of care.

Although the WHO SARA tracer indicators demonstrate high availability of basic equipment, facilities consistently reported needing additional units of commonly used items such as thermometers, blood pressure apparatuses and stethoscopes. This suggests that the principal challenge is not the presence of basic equipment, but ensuring enough to support multiple consultation rooms, health care providers and increasing patient workloads.

4.3 Standard precautions (DO3)

Standard precautions for infection prevention and control (IPC) are fundamental to delivering safe health care and preventing the transmission of infections within health facilities. These essential measures - including hand hygiene, safe management of sharps and infectious waste, availability of disinfectants and personal protective equipment, and adherence to infection prevention guidelines - protect patients, health care workers and the wider community from health care-associated infections. High availability is therefore a key indicator of facility readiness to deliver safe, quality health services.

The DO3 domain assesses the availability of nine tracer indicators representing the minimum infection prevention and control measures required to support safe service delivery. The DO3 percentage score is calculated by dividing the number of tracer indicators present on the day of the visit by 9.

Formula:

$$\textbf{DO3} = \frac{I9 + I10 + I11 + I12 + I13 + I14 + I15 + I16 + I17}{9} * 100\%$$

where:
I9 = Safe Sharps Disposal
I10 = Safe Infectious Waste Disposal
I11 = Appropriate Sharps Storage
I12 = Appropriate Waste Storage
I13 = Disinfectant (Chlorine Based)
I14 = Single Use / Auto Disable Syringes
I15 = Soap and Running Water
I16 = Latex Gloves
I17 = Infection Prevention Guidelines

4.3.1 Safe sharps disposal (I9)

Safe disposal of sharps ensures that used needles, blades and other sharp instruments are treated or disposed of in a manner that prevents needlestick injuries and environmental contamination. Appropriate final disposal methods, including functioning incineration or protected off-site disposal systems, are essential for reducing the risk of transmission of blood-borne infections. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Safe final disposal of sharps includes incineration, open burning in protected area, dump without burning in protected area, or remove offsite with protected storage. If method is incineration, incinerator functioning and fuel available.

- ☐ 85% (308/362) of facilities practices safe sharps disposal.

The SARA assessment indicates that almost three quarters of all facilities 71% (258/362) reported storing filled sharps containers before off-site removal by a third-party waste management contractor, making this the most common method of sharps disposal and indicating that centralized waste treatment systems are widely used. Only 14% (50/362) of facilities relied on on-site treatment, including 11% (40/362) using low-temperature single-chamber incinerators and 3% (10/362) using high-temperature two-chamber incinerators. An additional 6% (23/362) reported open burning in a protected pit and 0.3% (1/362) used protected burial, both of which are recognised as acceptable disposal methods under the WHO SARA methodology where appropriate.

Family Polyclinics and Multidisciplinary Central Polyclinics reported the highest use of protected off-site storage and removal, with 52% (60/115) and 58% (45/78) respectively using this method. In contrast, Type II Family Polyclinics had the lowest use of protected off-site storage and removal, at 41% (30/73), and the highest proportion using unprotected interim storage, at 27% (20/73), indicating the largest gap in protected sharps storage among the surveyed facility types.Family Polyclinic Type 2 Branches showed the greatest variation in disposal practices, with 46% (11/24) using protected off-site disposal but also 21% (5/24) relying on unprotected storage, while a small proportion reported alternative disposal methods or open dumping. This suggests that waste management systems are less consistent in lower-level branch facilities.

Facility Type	Stored in protected location and removed offsite	Stored in unprotected location and removed offsite	Burned in low temperature 1-chamber drum/brick incinerator	Open burning in pit	Burned in high temperature 2-chamber industrial incinerator (800-1000+° c)	Dumped without burning in covered pit or pit latrine	No Sharps	Dumped without burning in open pit	Other
Family Polyclinic (n=115)	60	20	15	10	1	1	7	0	1
Multidisciplinary Central Polyclinic (n=78)	45	17	5	2	1	0	8	0	0
Family Polyclinic Type 1 (n=72)	33	17	8	5	4	0	3	0	2
Family Polyclinic Type 2 (n=73)	30	20	12	4	3	0	4	0	0
Family Polyclinic Type 2 Branch (n=24)	11	5	0	2	1	0	2	1	2
Grand Total (n=362)	**179**	**79**	**40**	**23**	**10**	**1**	**24**	**1**	**5**

Table 53: Reported methods of sharps storage and disposal, by facility type

The SARA assessment indicates that off-site removal was the predominant reported approach to sharps waste management, used by 71% of surveyed facilities. However, the assessment did not establish whether off-site removal was organised through a centralized treatment system or whether final treatment complied with applicable safety requirements. This is consistent with modern health care waste management practices. The principal challenge is therefore not the absence of disposal systems but ensuring that interim storage before collection is safe and protected. Future investment should prioritise improving protected interim storage for facilities using centralized waste disposal systems, particularly Family Polyclinic Type 2 facilities and branch facilities. Strengthening waste collection services, providing appropriate sharps storage infrastructure and ensuring compliance with national health care waste management procedures would substantially improve safe sharps disposal without requiring widespread installation of on-site incinerators.

Although the WHO SARA methodology recognises several methods of final sharps disposal, including on-site incineration and protected open burning, international best practice has evolved in recent years. WHO[5] now recommends phasing out small, low-temperature health care waste incinerators where feasible because incomplete combustion can release hazardous pollutants, including dioxins, furans and particulate matter, while modern centralized treatment technologies provide safer and more environmentally sustainable alternatives. Consequently, the relatively low reported use of onsite incineration shoudl not,by itselfm be interpreted as a readiness gap. Instead, priority should be given to secure interim sharps storage, reliable collection and access to safe final treatment. Any recommendation to phase out or expand particular treatment technologies should be aligned with national health care waste management requirements and explicitly cited WHO guidance.

5 Overview of technologies for the treatment of infectious and sharp waste from health care facilities (WHO, 2019)

4.3.2 Safe infectious waste disposal (I10)

Safe final disposal of infectious health care waste prevents the spread of infectious agents to health care workers, waste handlers, patients and surrounding communities. Appropriate treatment or protected off-site disposal of infectious waste is a fundamental component of infection prevention and environmental safety. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Safe final disposal of infectious wastes includes incineration, open burning in protected area, dump without burning in protected area, or remove offsite with protected storage. If method is incineration, incinerator functioning and fuel available.

- ☐ 53% (192/362) of facilities practices safe infectious waste disposal.

The assessment found that protected interim storage followed by off-site removal was the most commonly reported infectious waste management pathway, used by 36% (125/362) of facilities. Overall, the findings show that off-site removal was more common than onsite treatment; however, the assessment does not establish how the waste was subsequently treated or whether it formed part of a centralized treatment system.

This indicates that centralized health care waste treatment is the predominant approach for managing infectious medical waste in Uzbekistan. More than one-quarter of facilities (17%, 62/362) stored infectious waste in an unprotected location before off-site removal, a practice that does not meet the WHO SARA definition of safe final disposal. This represents the largest gap in compliance with the WHO tracer indicator and may increase the risk of accidental exposure and environmental contamination. Only 8% (29/362) of facilities relied on on-site incineration, including 7% (26/362) using low-temperature single-chamber incinerators and 1% (3/362) using high-temperature two-chamber incinerators. A further 3% (12/362) reported open burning in a protected pit, while less than 1% (1/362) reported an alternative disposal method. Multidisciplinary Central Polyclinics recorded the highest use of protected interim storage followed by off-site removal, withat 70% (51/73), while21% (15/73) used unprotected storage before collection. Family Polyclinics also showed relatively good performance, with 58% (51/88) using protected off-site disposal. In contrast, Family Polyclinic Type 1 and Family Polyclinic Type 2 facilities were considerably less likely to use protected storage (37%, 11/30 and 32%, 12/37, respectively) and were much more likely to store infectious waste in unprotected locations (43%, 13/30 and 49%, 18/37, respectively), indicating weaker waste management systems at lower-level facilities.

Facility Type	Stored in protected location and removed offsite	Stored in unprotected location and removed offsite	Burned in low temperature 1-chamber drum/brick incinerator	Open burning in pit	Burned in high temperature 2-chamber industrial incinerator (800-1000+° c)	Other
Family Polyclinic (n=115)	51	15	17	5	0	0
Multidisciplinary Central Polyclinic (n=78)	11	13	1	3	2	0
Family Polyclinic Type 1 (n=72)	12	18	4	2	0	1
Family Polyclinic Type 2 (n=73)	0	1	0	0	0	0
Family Polyclinic Type 2 Branch (n=24)	51	15	4	2	1	0
Grand Total (n=362)	**125**	**62**	**26**	**12**	**3**	**1**

Table 54: Infectious waste disposal methods

The findings indicate that off-site removal is the most frequently reported approach to infectious waste management. However, the assessment does not provide information on the safety, technology or regulatory compliance of final off-site treatment.

More than one-quarter of facilities continue to store infectious waste in unprotected locations before collection, preventing compliance with the WHO SARA definition of safe final disposal. The most immediate gap identified by the assessment is unsafe interim storage before off-site collection, reported by 62 facilities. Future investment should prioritise secure, covered waste storage areas and reliable waste collection services, particularly in Family Polyclinic Type I and Type II facilities, where unprotected storage is most common. While the WHO SARA methodology recognises low-temperature incineration and protected open burning as acceptable disposal methods, current WHO guidance favours centralized treatment systems and the progressive replacement of small health care incinerators because of concerns regarding emissions of hazardous pollutants such as dioxins, furans and particulate matter. Strengthening centralized waste management systems therefore offers the greatest opportunity to improve both compliance with WHO standards and environmental performance.



Figure 66. Low temperature incinerator, Family Polyclinic #8, Mingbuloq, Namangan



Figure 67. Low temperature incinerator, #16 Family Polyclinic Type 1, Ishtikhan, Samarkand



Figure 68. Low temperature incinerator, #9 Family Polyclinic Type 2, Chortoq, Namangan



Figure 69. Low temperature incinerator, Family Polyclinic #23, Denov, Surkhandarya



Figure 70. Low temperature incinerator, Multidisciplinary Central Polyclinic, Oltinsoy, Surkhandarya



Figure 71. Low temperature incinerator, Multidisciplinary Central Polyclinic, Sariosiyo, Surkhandarya

4.3.3 Appropriate sharps storage (I11)

Appropriate sharps containers provide a secure, puncture-resistant means of collecting used needles and other sharp instruments at the point of care. Proper storage of sharps before final disposal reduces the risk of accidental injury and exposure to blood-borne pathogens among health care workers and waste handlers. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



A puncture-resistant, rigid, leak-resistant container designed to hold used sharps safely during collection, disposal and destruction. Sharps containers should be made of plastic, metal, or cardboard and have a lid that can be closed. Sharps containers should be fitted with a sharps aperture, capable of receiving syringes and needle assemblies of all standard sizes, together with other sharps. Boxes must be clearly marked with the international bio-hazard warning not less than 50mm diameter, printed in black or red on each of the front and back faces of the box.

- ☐ 87% (314/362) at all waste generation points.
- ☐ 10% (37/362) at some of the waste generation points.
- ☐ 3% (11/362) at none of the waste generation points.

The SARA assessment showed that medical waste segregation was implemented at all waste generation points in 87% (314/362) of facilities, indicating that most primary health care facilities have established systems for separating general, infectious and sharps waste at the point of generation. A further 10% (37/362) of facilities reported segregating waste at only some waste generation points, suggesting inconsistent implementation of waste management procedures within facilities and an increased risk of hazardous and non-hazardous waste becoming mixed. Only 3% (11/362) of facilities reported no segregation of medical waste at any waste generation point, indicating that complete absence of waste segregation was uncommon nationally. Multidisciplinary Central Polyclinics and Family Polyclinic Type 2 facilities demonstrated the highest compliance, with waste segregated at all waste generation points in 95% (74/78) and 95% (69/73) of facilities, respectively. Family Polyclinics and Family Polyclinic Type 1 facilities also performed well, with complete waste segregation reported by 87% (100/115) and 86% (62/72) of facilities, respectively. Family Polyclinic Type 2 Branches performed substantially worse than all other facility types, with only 38% (9/24) segregating waste at all generation points, while 25% (6/24) reported segregation at only some locations and 38% (9/24) reported no waste segregation at any generation point. This indicates a significant gap in basic health care waste management practices at branch facilities.

Facility Type	All Count	%	Some Count	%	None Count	%
Family Polyclinic (n=115)	100	87%	14	12%	1	1%
Multidisciplinary Central Polyclinic (n=78)	74	95%	3	4%	1	1%
Family Polyclinic Type 1 (n=72)	62	86%	10	14%	0	0%
Family Polyclinic Type 2 (n=73)	69	95%	4	5%	0	0%
Family Polyclinic Type 2 Branch (n=24)	9	38%	6	25%	9	38%
Grand Total (n=362)	**314**	**87%**	**37**	**10%**	**11**	**3%**

Table 55: Waste is separated into 3 types at all generation points by facility type

The findings demonstrate that waste segregation is well established across most primary health care facilities in Uzbekistan, with nearly nine out of ten facilities consistently separating general, infectious and sharps waste at all points of generation. However, implementation is considerably weaker in Family Polyclinic Type 2 Branches, where inconsistent or absent waste segregation suggests deficiencies in waste management infrastructure, staff training or supervision. As effective segregation is the foundation of safe health care waste management, strengthening these practices at branch facilities should be a priority. Efforts should focus on achieving universal waste segregation at the point of generation by ensuring all consultation rooms and treatment areas are equipped with appropriately colour-coded waste containers and sharps boxes, supported by staff training, supervision and routine monitoring. Particular attention should be given to Family Polyclinic Type 2 Branches, where improvements in waste segregation would substantially reduce occupational and environmental risks while improving compliance with national and WHO infection prevention and control standards.



Figure 72. Sharps boxes, Multidisciplinary Central Polyclinic, Yakkasaray, Tashkent City



Figure 73. Waste separation, Family Polyclinic #32, Yashnobod, Tashkent City

4.3.4 Appropriate waste storage (I12)

Appropriate storage of infectious waste in covered, leak-resistant receptacles supports the safe segregation and temporary storage of hazardous health care waste prior to collection or disposal. This reduces the risk of contamination and accidental exposure within health care facilities.

- ☐ 35% (125/362) of facilities stored waste in a safe location.

The assessment found that protected off-site disposal using a third-party waste management company was the most common method of final infectious waste disposal, reported by 35% (125/362) of facilities. This indicates that centralized health care waste treatment is the predominant approach for managing infectious medical waste in Uzbekistan. More than one-quarter of facilities (17%, 62/362) stored infectious waste in an unprotected location before off-site removal, a practice that does not meet the WHO SARA definition of safe final disposal. This represents the largest gap in compliance with the WHO tracer indicator and may increase the risk of accidental exposure and environmental contamination. Only 8% (29/362) of facilities relied on on-site incineration, including 7% (26/362) using low-temperature single-chamber incinerators and 1% (3/362) using high-temperature two-chamber incinerators. A further 3% (12/362) reported open burning in a protected pit, while less than 1% (1/362) reported an alternative disposal method. Multidisciplinary Central Polyclinics demonstrated the strongest waste management practices, with 70% (51/73) using protected off-site disposal and only 21% (15/73) relying on unprotected storage before collection. Family Polyclinics also showed relatively good performance, with 58% (51/88) using protected off-site disposal. In contrast, Family Polyclinic Type 1 and Family Polyclinic Type 2 facilities were considerably less likely to use protected storage (37%, 11/30 and 32%, 12/37, respectively) and were much more likely to store infectious waste in unprotected locations (43%, 13/30 and 49%, 18/37, respectively), indicating weaker waste management systems at lower-level facilities. Only one Type II Branch had an infectious waste disposal method recorded, and it reported unprotected storage before off-site removal. This single observation is insufficient to characterise waste management practices across branch facilities.

Facility Type	Stored in protected location and removed offsite	Stored in unprotected location and removed offsite	Burned in low temperature 1-chamber drum/brick incinerator	Open burning in pit	Burned in high temperature 2-chamber industrial incinerator (800-1000+° c)	Other
Family Polyclinic (n=115)	51	15	17	5	0	0
Multidisciplinary Central Polyclinic (n=78)	11	13	1	3	2	0
Family Polyclinic Type 1 (n=72)	12	18	4	2	0	1
Family Polyclinic Type 2 (n=73)	0	1	0	0	0	0
Family Polyclinic Type 2 Branch (n=24)	51	15	4	2	1	0
Grand Total (n=362)	**125**	**62**	**26**	**12**	**3**	**1**

Table 56: Waste storage and disposal methods, by facility type

The findings indicate that infectious health care waste management in Uzbekistan is based primarily on third party waste contractor off-site treatment rather than on-site disposal, consistent with modern health care waste management practice. However, more than one-quarter of facilities continue to store infectious waste in unprotected locations before collection, preventing compliance with the WHO SARA definition of safe final disposal. The principal challenge therefore lies in strengthening safe interim storage and waste collection systems rather than expanding on-site treatment capacity. Future investment should prioritise secure, covered waste storage areas and reliable waste collection services, particularly in Family Polyclinic Type 1 and Type 2 facilities, where unprotected storage is most common. While the WHO SARA methodology recognises low-temperature incineration and protected open burning as acceptable disposal methods, current WHO guidance favours centralized treatment systems and the progressive replacement of small health care incinerators because of concerns regarding emissions of hazardous pollutants such as dioxins, furans and particulate matter. Strengthening centralized waste management systems therefore offers the greatest opportunity to improve both compliance with WHO standards and environmental performance.



Figure 74. Waste storage, Multidisciplinary Central Polyclinic, Nurafshon, Tashkent Region



Figure 75. Waste storage, Family Polyclinic #9, Navbahor, Navoi

4.3.5 Disinfectant (I13)

Disinfectants, including chlorine-based or other nationally approved products, are essential for the decontamination of clinical surfaces, equipment and spills contaminated with blood or body fluids. Their availability supports routine environmental cleaning and helps reduce the transmission of health care-associated infections. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Chlorine-based or other country specific used for environmental disinfection.

- ☐ 85% (306/362) of facilities had a chlorine-based or other nationally approved environmental disinfectant present.

The SARA survey found that chlorine-based or other nationally approved environmental disinfectants were available in 85% (306/362) of facilities, indicating that most primary health care facilities had access to the essential disinfectants required for routine environmental cleaning and decontamination. Family Polyclinic Type 2 facilities demonstrated the highest availability, with disinfectants present in 90% (66/73) of facilities, followed by Family Polyclinics at 88% (101/115). Multidisciplinary Central Polyclinics also showed high availability, with 85% (66/78) of facilities having disinfectants available on the day of the survey. Family Polyclinic Type 1 facilities had slightly lower availability, with 81% (58/72) meeting the tracer indicator, suggesting that approximately one in five facilities lacked an essential environmental disinfectant. The largest gap was observed in Type II Branches, where disinfectants were available in only 15 of 24 facilities (63%), while nine branches (37%) did not meet the tracer indicator.

The absence of environmental disinfectant cannot be explained by the differentiated functions of post-reform facilities, as these products are required in every facility providing patient care. The findings therefore identify a specific readiness gap in Type II Branches and, to a lesser extent, Type I Family Polyclinics.

Procurement and distribution arrangements should ensure that nationally approved environmental disinfectants are consistently available in all PHC facilities, with priority given to the nine affected branches and 14 affected Type I facilities. The indicator confirms availability on the day of assessment but does not establish continuity of supply, correct preparation or appropriate use.

Overall, environmental disinfectant availability was high in pre-reform Family Polyclinics and post-reform Type II facilities. The principal remaining gap is concentrated in Type II Branches, where more than one-third lacked this essential IPC supply.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	101	88%	14	12%
Multidisciplinary Central Polyclinic (n=78)	66	85%	12	15%
Family Polyclinic Type 1 (n=72)	58	81%	14	19%
Family Polyclinic Type 2 (n=73)	66	90%	7	10%
Family Polyclinic Type 2 Branch (n=24)	15	63%	9	37%
Grand Total (n=362)	**306**	**85%**	**56**	**15%**

Table 57: Availability of chlorine-based or other nationally approved environmental disinfectant, by facility type

The SARA assessment showed that environmental disinfectants were widely available across Uzbekistan's primary health care system, reflecting generally good readiness to support routine environmental cleaning and infection prevention. However, one in seven facilities nationally lacked an appropriate disinfectant on the day of the survey, with the largest gaps occurring in Family Polyclinic Type 2 Branches. As effective environmental cleaning depends on the consistent availability of disinfectants, these shortages may compromise routine infection prevention practices, particularly in lower-level facilities. Procurement and supply chain systems should ensure uninterrupted availability of nationally approved environmental disinfectants in all primary health care facilities, with particular attention to Family Polyclinic Type 2 Branches. Regular stock monitoring, forecasting and distribution should be strengthened to eliminate stock-outs and support consistent implementation of routine cleaning and disinfection protocols.

4.3.6 Single use / auto-disable syringes (I14)

Single-use and auto-disable syringes are essential for safe injection practices by preventing the reuse of injection equipment between patients. Their availability reduces the risk of transmission of blood-borne infections and supports safe delivery of immunisation and other injectable treatments. Under the WHO SARA methodology, a facility is awarded one point if single use or auto disable syringes are observed on the day of the assessment.

- ☐ 74% (267/362) had auto-disable or single-use syringes available.
- ☐ 26% (95/362) did not have auto-disable or single-use syringes available.

The SARA assessment found that 74% (267/362) of primary health care facilities had auto-disable or single-use syringes available in the immunization service area on the day of the assessment, indicating generally good implementation of safe injection practices. However, 26% (95/362) of facilities lacked these essential immunization commodities, meaning that approximately one in four facilities did not have WHO-recommended syringes available at the time of the survey. Availability was highest in Family Polyclinics (81%; 93/115), followed by Family Polyclinic Type II facilities (79%; 58/73) and Multidisciplinary Central Polyclinics (74%; 58/78). Lower availability was observed in Family Polyclinic Type I facilities (68%; 49/72), while Family Polyclinic Type II Branches demonstrated substantially lower coverage, with only 38% (9/24) reporting the availability of auto-disable or single-use syringes. This suggests important disparities in the distribution of immunization commodities between higher-level facilities and branch facilities.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	93	81%	22	19%
Multidisciplinary Central Polyclinic (n=78)	58	74%	20	26%
Family Polyclinic Type 1 (n=72)	49	68%	23	32%
Family Polyclinic Type 2 (n=73)	58	79%	15	21%
Family Polyclinic Type 2 Branch (n=24)	9	38%	15	63%
Grand Total (n=362)	**267**	**74%**	**95**	**26%**

Table 58: Availability of single-use or auto-disable syringes on the day of assessment, by facility type

The findings demonstrate that injection safety has been largely established across Uzbekistan's primary health care system, although gaps remain in the availability of auto-disable or single-use syringes. As these syringes are a fundamental requirement for safe immunization and are recommended by WHO for

all vaccination services, achieving universal availability should remain a national priority. Attention should be given to strengthening procurement and distribution systems for lower-level facilities, especially Family Polyclinic Type II Branches, to ensure uninterrupted availability of safe injection equipment and reduce the risk of unsafe injection practices.

4.3.7 Soap and running water or alcohol-based hand rub (I15)

Hand hygiene is the single most effective measure for preventing health care-associated infections. The availability of soap and running water or alcohol-based hand rub enables health care workers to perform hand hygiene before and after patient contact, reducing the transmission of infectious microorganisms. Under the WHO SARA methodology, a facility is awarded one point if there is soap and running water or alcohol-based hand rub at points of care.

- ☐ 77% (279/362) all points of patient care.
- ☐ 16% (58/362) some points of patient care.
- ☐ 7% (25/362) none.

The SARA assessment found that 77% (279/362) of primary health care facilities had functioning hand hygiene stations with running water and soap available at all points of patient care, indicating that hand hygiene infrastructure has been established across most facilities. A further 16% (58/362) of facilities reported hand hygiene stations at only some patient care locations, suggesting inconsistent access to hand hygiene during routine clinical care. Seven percent (25/362) of facilities had no functioning hand hygiene stations with running water and soap at patient care points, indicating that basic hand hygiene infrastructure remains absent in a small but important proportion of facilities. Availability was highest in Family Polyclinics (84%; 97/115), followed by Family Polyclinic Type II facilities (81%; 59/73) and Multidisciplinary Central Polyclinics (79%; 62/78). Family Polyclinic Type I facilities reported slightly lower coverage, with 72% (52/72) providing hand hygiene stations at all patient care points. Family Polyclinic Type II Branches performed substantially worse than all other facility types, with only 38% (9/24) providing hand hygiene stations at all patient care points, while 29% (7/24) had hand hygiene stations at only some locations and 33% (8/24) had none available. This indicates a significant gap in basic infection prevention infrastructure within branch facilities.

Facility Type	All	%	Some	%	None	%
Family Polyclinic (n=115)	97	84%	15	13%	3	3%
Multidisciplinary Central Polyclinic (n=78)	62	79%	15	19%	1	1%
Family Polyclinic Type 1 (n=72)	52	72%	11	15%	9	13%
Family Polyclinic Type 2 (n=73)	59	81%	10	14%	4	5%
Family Polyclinic Type 2 Branch (n=24)	9	38%	7	29%	8	33%
Grand Total (n=362)	**279**	**77%**	**58**	**16%**	**25**	**7%**

Table 59: Availability of soap and running water or alcohol-based hand rub at points of care, by facility type

The findings demonstrate that hand hygiene infrastructure is established across most primary health care facilities in Uzbekistan. However, almost one in four facilities either lacked hand hygiene stations at some patient care locations or had none available, limiting opportunities for health care workers to perform hand

hygiene at the point of care. Performance was particularly poor in Family Polyclinic Type II Branches, where limited access to hand hygiene stations represents an important weakness in infection prevention and control. Future investment should focus on achieving universal access to functioning hand hygiene stations at every point of patient care, supported by reliable water supplies, soap availability, routine maintenance and regular monitoring, with particular attention given to strengthening lower-level branch facilities.

4.3.8 Latex gloves (I16)

Disposable examination gloves, including suitable non-latex alternatives where appropriate, provide a protective barrier against exposure to blood, body fluids and infectious materials during patient care. Their availability supports the implementation of standard precautions and reduces the risk of cross-infection. Under the WHO SARA methodology, a facility is awarded one point if latex gloves or their equivalent are observed to be present on the day of assessment.

- ☐ 86% (310/362) had disposable latex gloves available.
- ☐ 14% (52/362) did not have disposable latex gloves available.

The SARA assessment found that 86% (310/362) of primary health care facilities had disposable latex gloves available on the day of the assessment, indicating that this essential infection prevention commodity was available in most facilities. However, 14% (52/362) of facilities lacked disposable latex gloves, meaning that approximately one in seven facilities did not have this basic protective equipment available at the time of the survey. Availability was highest in Family Polyclinics (90%; 104/115) and Multidisciplinary Central Polyclinics (90%; 70/78), followed closely by Family Polycllinic Type II facilities (89%; 65/73). Slightly lower availability was observed in Family Polyclinic Type I facilities (83%; 60/72). Family Polyclinic Type II Branches demonstrated substantially lower availability than all other facility types, with only 46% (11/24) reporting disposable latex gloves available and 54% (13/24) lacking this essential IPC commodity. This indicates an important disparity in the distribution of basic infection prevention supplies between higher-level facilities and branch facilities.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	104	90%	11	10%
Multidisciplinary Central Polyclinic (n=78)	70	90%	8	10%
Family Polyclinic Type 1 (n=72)	60	83%	12	17%
Family Polyclinic Type 2 (n=73)	65	89%	8	11%
Family Polyclinic Type 2 Branch (n=24)	11	46%	13	54%
Grand Total (n=362)	**310**	**86%**	**352**	**14%**

Table 60: Availability of disposable examination gloves or equivalent products on the day of assessment, by facility type

The findings demonstrate that disposable latex gloves are available in most primary health care facilities across Uzbekistan, providing a strong foundation for safe clinical practice and infection prevention. However, the absence of gloves in approximately one in seven facilities represents an avoidable risk to patient safety, occupational health and infection prevention and control. Performance was particularly poor in Family Polyclinic Type II Branches, where more than half of facilities lacked disposable gloves on the day of the

assessment. Achieving universal availability of disposable gloves should therefore remain a priority through strengthened procurement and supply chain management, with particular attention given to lower-level branch facilities to ensure uninterrupted access to this essential infection prevention commodity.

4.3.9 Infection prevention guidelines (I17)

Guidelines for standard precautions provide health care workers with evidence-based procedures for preventing the transmission of infectious diseases during routine patient care. Access to current guidelines promotes consistent implementation of infection prevention and control practices and supports staff training and quality improvement. Under the WHO SARA methodology, a facility is awarded one point if they have a copy of National guidelines for infection prevention and control present in the service area.

- ☐ 57% (206/362) of health facilities had a copy that was observed.
- ☐ 19% (70/362) of health facilities had a copy that was reported but not seen.
- ☐ 24% (86/362) of health facilities did not have a copy present.

The SARA assessment found that 57% (206/362) of primary health care facilities had a copy of the standard precautions guidelines that was observed during the assessment, indicating that just over half of facilities had documented IPC guidance readily available for staff. A further 19% (70/362) of facilities reported having the guidelines, although no copy could be verified by the survey team. Twenty-four percent (86/362) of facilities had no standard precautions guidelines available, suggesting that nearly one quarter of facilities lacked access to this essential reference for safe clinical practice. Availability of observed guidelines was highest in Multidisciplinary Central Polyclinics (69%; 54/78), followed by Family Polyclinics (63%; 72/115). Lower levels were observed in Family Polyclinic Type II facilities (51%; 37/73) and Family Polyclinic Type I facilities (46%; 33/72). Family Polyclinic Type II Branches performed least well, with only 42% (10/24) having observed guidelines, while 54% (13/24) had no guidelines available. This indicates substantial gaps in access to basic IPC guidance, particularly within lower-level branch facilities.

Facility Type	Yes, observed	%	Yes, reported but not seen	%	No	%
Family Polyclinic (n=115)	72	63%	20	17%	23	20%
Multidisciplinary Central Polyclinic (n=78)	54	69%	12	15%	12	15%
Family Polyclinic Type 1 (n=72)	33	46%	17	24%	22	31%
Family Polyclinic Type 2 (n=73)	37	51%	20	27%	16	22%
Family Polyclinic Type 2 Branch (n=24)	10	42%	1	4%	13	54%
Grand Total (n=362)	**206**	**57%**	**70**	**19%**	**86**	**24%**

Table 61: Availability and verification of national infection prevention and control guidelines in the service area, by facility type

The findings demonstrate that access to standard precautions guidelines remains suboptimal across primary health care facilities in Uzbekistan. While over half of facilities had guidelines that could be verified during the assessment, nearly one quarter lacked any IPC guidance and a further one fifth reported having guidelines that could not be observed. Strengthening the availability and visibility of current IPC guidelines should therefore be a national priority. Particular attention should be given to Family Polyclinic Type I

facilities and Family Polyclinic Type II Branches by ensuring that up-to-date standard precautions guidelines are distributed to all facilities, displayed or readily accessible within clinical areas, and reinforced through regular staff orientation, supervision and infection prevention and contol training.

4.3.10 Standard precautions final score (DO3)

The DO3 standard precautions for infection prevention and control domain assesses the availability of nine tracer indicators representing the minimum infection prevention and control measures required to support routine primary health care. The DO3 percentage score is calculated by dividing the number of tracer indicators present on the day of the visit by 9.

Formula:

$$\textbf{D03} = \frac{I9 + I10 + I11 + I12 + I13 + I14 + I15 + I16 + I17}{9} * 100\%$$

where:
I9 = Safe final disposal of sharps
I10 = Safe final disposal of infectious wastes
I11 = Appropriate storage of sharps waste
I12 = Appropriate storage of infectious waste
I13 = Disinfectant
I14 = Single use —standard disposable or auto-disable syringes
I15 = Soap and running water or alcohol-based hand rub
I16 = Latex gloves
I17 = Guidelines for standard precautions

The final scores were as follows:

Standard Precautions for Infection Prevention and Control (DO3)	National Level	Family Polyclinic	Multidisciplinary Central Polyclinic	Family Polyclinic Type 1	Family Polyclinic Type 2	Family Polyclinic Type 2 Branch
	(n = 362)	(n = 115)	(n = 78)	(n = 72)	(n = 73)	(n = 24)
I9) Safe final disposal of sharps	85%	81%	94%	82%	86%	75%
I10) Safe final disposal of infectious wastes	53%	59%	86%	35%	44%	4%
I11) Appropriate storage of sharps waste	87%	87%	95%	86%	95%	38%
I12) Appropriate storage of infectious waste	67%	80%	94%	47%	53%	17%
I13) Disinfectant	85%	88%	85%	81%	90%	63%

I14) Single use standard disposable or auto-disable syringes	74%	81%	74%	68%	79%	38%
I15) Soap and running water or alcohol-based hand rub*	94%	95%	95%	90%	99%	79%
I16) Latex gloves	86%	90%	90%	83%	89%	46%
I17) Guidelines for standard precautions	76%	80%	85%	69%	78%	46%
Average Score DO3	**78%**	**82%**	**88%**	**71%**	**79%**	**45%**

* Methodological Note: Indicator I5 is scored as the presence of soap or alcohol-based hand rub in the facility – it should not be misinterpreted as presence at all points of care which was lower at 77% (279/362) (see section 4.3.7)

Table 62: SARA IPC tracer indicator scores (DO3) by facility type

The national Standard Precautions for Infection Prevention and Control (DO3) score was 78%, indicating that the essential measures required to protect patients and health care workers from health care-associated infections were generally available across primary health care facilities, although important gaps remain. Readiness varied considerably between facility types, with Multidisciplinary Central Polyclinics achieving the highest score (88%), followed by Family Polyclinics (82%) and Family Polyclinic Type II facilities (79%). Family Polyclinic Type I facilities recorded lower readiness (71%), while Family Polyclinic Type II Branches demonstrated substantially poorer performance (45%), reflecting significant weaknesses in infection prevention infrastructure, supplies and waste management.

Performance varied considerably across the nine tracer indicators. Soap and running water or alcohol-based hand rub (94%), appropriate sharps storage (87%), latex gloves (86%), safe final disposal of sharps (85%) and disinfectants (85%) were available in most facilities, demonstrating that several fundamental IPC measures have been widely established. In contrast, guidelines for standard precautions (76%), single-use or auto-disable syringes (74%), appropriate storage of infectious waste (67%) and particularly safe final disposal of infectious waste (53%) were considerably weaker, highlighting deficiencies in waste management systems, infection prevention governance and the consistent availability of essential IPC commodities. Family Polyclinic Type II Branches consistently recorded the lowest readiness across almost every tracer indicator.

The findings demonstrate that Uzbekistan has established a strong foundation for infection prevention and control within primary health care, with high national availability of hand hygiene facilities, sharps management systems, disinfectants and personal protective equipment. However, weaknesses remain in infectious waste management, the availability of IPC guidance and the provision of essential supplies in lower-level facilities. Future investment should prioritise strengthening infectious waste management systems, ensuring universal access to current IPC guidelines, and improving the availability of essential IPC commodities, particularly within Family Polyclinic Type II Branches. Continued supervision, staff training and routine monitoring will be essential to ensure that infection prevention and control standards are implemented consistently across all primary health care facilities.

Overall, the findings show that IPC readiness has been broadly maintained in Type II Family Polyclinics but remains lower in Type I facilities and substantially inadequate in Type II Branches. Improvement should focus first on the facility types and tracer indicators with the largest documented gaps, supported by reliable supply arrangements, safe waste-management systems, accessible national guidance and routine supportive supervision.

4.4 Diagnostic capacity (DO4)

Diagnostic capacity is essential for the timely detection, diagnosis and monitoring of common health conditions within primary health care. Access to basic onsite diagnostic tests - including haemoglobin, blood glucose, urine protein and glucose, pregnancy and syphilis testing - supports evidence-based clinical decision-making, appropriate treatment, timely referral and improved patient outcomes. High availability of WHO's essential diagnostic onsite tests is therefore a key indicator of facility readiness to deliver quality health services.

The DO4 domain assesses the availability of six tracer indicators representing the minimum point of care diagnostic capacity expected within all primary health care facilities. The DO4 percentage score is calculated by dividing the number of tracer indicators available onsite on the day of the visit by 6.

Formula:

$$\textbf{D04} = \frac{D1 + D2 + D4 + D5 + D9 + D11}{6} * 100\%$$

where:
D1 = Haemoglobin Test
D2 = Glucometer / Test Strips
D4 = Urine Protein Test
D5 = Urine Glucose Test
D9 = Syphilis Rapid Diagnostic Test (RDT)
D11 = Pregnancy Rapid Diagnostic Test (RDT)

4.4.1 Haemoglobin test (D1)

Rapid haemoglobin testing enables timely identification of anaemia at the point of care and supports appropriate diagnosis, treatment and referral, particularly for pregnant women, young children and patients with chronic disease. Portable haemoglobinometers and similar devices provide rapid, accurate results without requiring a fully equipped laboratory, improving access to essential diagnostic services in primary health care. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey.

- ☐ 12% (43/362) were able to perform a rapid haemoglobin test on-site with colorimeter, haemoglobinometer, or hemocue.
- ☐ 88% (319/362) could not perform a rapid haemoglobin test on-site.

The SARA assessment found that only 12% (43/362) of primary health care facilities were able to perform a rapid haemoglobin test on-site on the day of the assessment, indicating that access to point-of-care haemoglobin testing remains extremely limited across Uzbekistan's primary health care system. Consequently, 88% (319/362) of facilities were unable to provide this essential diagnostic service, potentially delaying the identification and management of anaemia and other conditions requiring haemoglobin

measurement. Availability was highest in Multidisciplinary Central Polyclinics (28%; 22/78), followed by Family Polyclinics (16%; 18/115). Availability was very limited in Family Polyclinic Type II facilities (4%; 3/73), while Family Polyclinic Type I facilities and Family Polyclinic Type II Branches reported no availability (0%; 0/72 and 0/24, respectively).

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	18	16%	97	84%
Multidisciplinary Central Polyclinic (n=78)	22	28%	56	72%
Family Polyclinic Type 1 (n=72)	0	0%	72	100%
Family Polyclinic Type 2 (n=73)	3	4%	70	96%
Family Polyclinic Type 2 Branch (n=24)	0	0%	24	100%
Grand Total (n=362)	**43**	**12%**	**319**	**88%**

Table 63: Ability to perform a rapid haemoglobin test on-site by facility type

It should be noted, however, that this does not necessarily mean patients lack access to haemoglobin testing as facilities may obtain these tests through Uzbekistan's centralized referral laboratory network. Hower, the WHO SARA methodology is designed to assess only tests that can be performed on-site and does not evaluate access through referral systems. WHO has selected rapid haemoglobin testing as a tracer indicator because it is a simple, low-cost point-of-care test that can be performed by appropriately trained primary health care staff without the need for a laboratory. Expanding the availability of portable haemoglobinometers and ensuring a reliable supply of consumables would strengthen diagnostic capacity, enable earlier detection and management of anaemia, reduce dependence on external laboratory services, and reduce the friction associated with waiting for results. Attention should be given to Family Polyclinic Type I, Family Polyclinic Type II and Family Polyclinic Type II Branch facilities, where on-site testing was minimal or absent. The operational priority should be to define clearly where onsite haemoglobin testing is required within the post-reform service package. Where the test is assigned to Type I, Type II or branch level, facilities should have functioning equipment, trained staff and a reliable supply of consumables. Where testing is provided through the centralised laboratory network, facilities should have dependable arrangements for specimen collection or patient referral, timely return of results and clinical follow-up.

The objective should not be to install haemoglobinometers in every facility automatically, but to ensure timely and reliable access to haemoglobin testing through the service-delivery arrangement assigned to each facility type.



Figure 76. Haemoglobin Tester, Multidisciplinary Central Polyclinic, Nurafshon City, Tashkent Region



Figure 77. Haemoglobin Tester, Family Polyclinic #102, Baghdad, Fergana



Figure 78. Example of HemoCue 301 Kit – Not a Photo from the Survey



Figure 79. Example of Rapid Hemoglobin Tester – Not a Photo from the Survey

4.4.2 Glucometer test (D2)

Rapid blood glucose testing is an essential point-of-care diagnostic service for the detection and management of diabetes mellitus, hypoglycaemia and other metabolic disorders. Portable blood glucometers with compatible test strips enable health care workers to rapidly assess blood glucose levels during routine consultations, facilitating timely diagnosis, treatment and referral without requiring laboratory services, improving access to essential diagnostic services in primary health care. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey.

- ☐ 35% (126/362) were able to perform a rapid blood glucose test using both a glucometer and test strips.
- ☐ 65% (236/362) could not perform a rapid blood glucose test.

The SARA assessment found that 35% (126/362) of primary health care facilities were able to perform a rapid blood glucose test on-site on the day of the assessment. Consequently, 65% (236/362) of facilities were unable to provide this essential diagnostic service, reducing opportunities for immediate assessment and management of patients with suspected diabetes or acute disturbances in blood glucose levels. Availability was highest in Multidisciplinary Central Polyclinics (50%; 39/78), followed by Family Polyclinic Type II facilities (36%; 26/73), Family Polyclinics (33%; 38/115) and Family Polyclinic Type I facilities (31%; 22/72). Family Polyclinic Type II Branches demonstrated substantially lower availability, with only 4% (1/24) able to perform rapid blood glucose testing. This indicates that point-of-care blood glucose testing remains concentrated in higher-level facilities, with very limited access in branch facilities.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	38	33%	77	67%
Multidisciplinary Central Polyclinic (n=78)	39	50%	39	50%
Family Polyclinic Type 1 (n=72)	22	31%	50	69%
Family Polyclinic Type 2 (n=73)	26	36%	47	64%
Family Polyclinic Type 2 Branch (n=24)	1	4%	23	96%
Grand Total (n=362)	**126**	**35%**	**236**	**65%**

Table 64: Ability to perform a rapid blood glucose test on-site, by facility type

It should be noted, however, that this does not necessarily mean patients lack access to blood glucose testing. Many facilities may obtain these tests through Uzbekistan's centralized referral laboratory network, although the WHO SARA methodology assesses only tests that can be performed on-site and does not evaluate access through referral systems. WHO has selected rapid blood glucose testing as a tracer indicator because it is a simple, low-cost point-of-care test that can be performed by appropriately trained primary health care staff without requiring laboratory infrastructure. Expanding the availability of glucometers and ensuring a reliable supply of compatible test strips would strengthen the early diagnosis and management of diabetes and other metabolic disorders while reducing dependence on external laboratory services, and reduce the friction associated with waiting for results. Attention should be given to Family Polyclinic Type II Branches, where on-site testing was almost entirely absent.



Figure 80. Glucometer, #3 Family Polyclinic Type 1, Kuvasay, Fergana

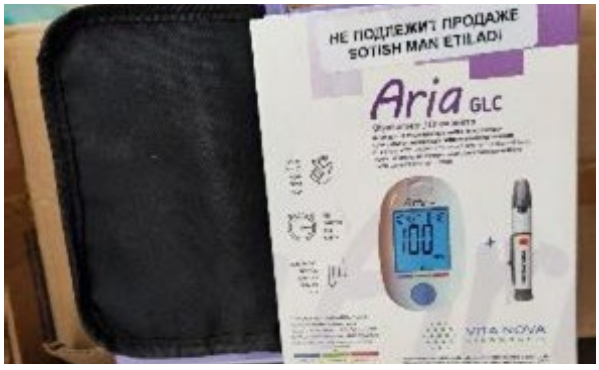


Figure 81. Glucometer, Multidisciplinary Central Polyclinic, Karakul, Bukhara



Figure 82. Glucometer, Family Polyclinic #17, Namangan City



Figure 83. Glucometer, Family Polyclinic #12, Vobkent, Bukhara

4.4.3 Urine protein test (D4)

Rapid urine protein testing is a simple point-of-care diagnostic used to detect proteinuria, supporting the early diagnosis and management of hypertensive disorders of pregnancy, kidney disease and other medical conditions. The test can be performed using urine dipsticks by appropriately trained primary health care staff without requiring laboratory equipment, enabling immediate clinical decision-making during patient consultations. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey.

- ☐ 9% (33/362) were able to perform a rapid urine protein test on-site.
- ☐ 91% (329/362) could not perform a rapid urine protein test on-site.

The SARA assessment found that only 9% (33/362) of primary health care facilities were able to perform a rapid urine protein test on-site. Consequently, 91% (329/362) of facilities were unable to provide immediate urine protein testing, limiting opportunities for the early detection and management of proteinuria during routine consultations. Availability was highest in Multidisciplinary Central Polyclinics (24%; 19/78), followed by Family Polyclinics (8%; 9/115) and Family Polyclinic Type II facilities (5%; 4/73). Family Polyclinic Type I facilities reported almost no availability (1%; 1/72), while Family Polyclinic Type II Branches had no on-site urine protein testing capability (0%; 0/24).

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	9	8%	106	92%
Multidisciplinary Central Polyclinic (n=78)	19	24%	59	76%
Family Polyclinic Type 1 (n=72)	1	1%	71	99%
Family Polyclinic Type 2 (n=73)	4	5%	69	95%
Family Polyclinic Type 2 Branch (n=24)	0	0%	24	100%
Grand Total (n=362)	**33**	**9%**	**329**	**91%**

Table 65: Ability to perform a rapid urine protein test on-site by facility type

It should be noted, however, that this does not necessarily mean patients lack access to urine protein testing. Many facilities may obtain these tests through Uzbekistan's centralized referral laboratory network, although the WHO SARA methodology assesses only tests that can be performed on-site and does not evaluate access through referral systems. WHO has selected rapid urine protein testing as a tracer indicator because it is a simple, inexpensive point-of-care test that can be performed by appropriately trained primary health care staff without laboratory infrastructure. Expanding the availability of low-cost urine dipsticks would strengthen the early detection and management of hypertensive disorders of pregnancy, kidney disease and other conditions, while reducing dependence on external laboratory services, and reduce the friction associated with waiting for results. Attention should be given to Family Polyclinic Type I, Family Polyclinic Type II and Family Polyclinic Type II Branch facilities, where on-site testing was almost entirely absent.



Figure 84. Example of Rapid Urine Test Strips Multistix 10 SG (Siemens) – Not a Photo from the Survey



Figure 85. Example of Rapid Urine Test Strips Multistix 10 SG (Siemens) – Not a Photo from the Survey

4.4.4 Urine glucose test (D5)

Rapid urine glucose testing is a simple point-of-care diagnostic used to detect glycosuria, supporting the identification and management of diabetes mellitus and other disorders affecting glucose metabolism. The test can be performed using low-cost urine dipsticks by appropriately trained primary health care staff without requiring laboratory equipment, enabling immediate clinical assessment during routine patient consultations. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey.

- ☐ 10% (35/362) were able to perform a rapid urine glucose test on-site.
- ☐ 90% (327/362) could not perform a rapid urine glucose test on-site.

The SARA assessment found that only 10% (35/362) of primary health care facilities were able to perform a rapid urine glucose test on-site. Consequently, 90% (327/362) of facilities were unable to provide immediate urine glucose testing, limiting opportunities for the rapid assessment of patients with suspected diabetes mellitus and other disorders associated with glycosuria. Availability was highest in Multidisciplinary Central Polyclinics (24%; 19/78), followed by Family Polyclinics (10%; 11/115) and Family Polyclinic Type II facilities (5%; 4/73). Family Polyclinic Type I facilities reported almost no availability (1%; 1/72), while Family Polyclinic Type II Branches had no on-site urine glucose testing capability (0%; 0/24). These findings indicate that rapid urine glucose testing remains concentrated in a small number of higher-level facilities, with virtually no availability in lower-level primary health care facilities.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	11	10%	104	90%
Multidisciplinary Central Polyclinic (n=78)	19	24%	59	76%
Family Polyclinic Type 1 (n=72)	1	1%	71	99%
Family Polyclinic Type 2 (n=73)	4	5%	69	95%
Family Polyclinic Type 2 Branch (n=24)	0	0%	24	100%
Grand Total (n=362)	**35**	**10%**	**327**	**90%**

Table 66: Ability to perform a rapid urine glucose test on-site, by facility type

It should be noted, however, that this does not necessarily mean patients lack access to urine glucose testing. The WHO SARA methodology assesses only tests that can be performed on-site and does not evaluate access through referral systems. WHO has selected rapid urine glucose testing as a tracer indicator because it is a simple, inexpensive point-of-care test that can be performed by appropriately trained primary health care staff without laboratory infrastructure. Expanding the availability of urine dipsticks would strengthen the early identification of diabetes and other metabolic disorders while reducing dependence on external laboratory services. Attention should be given to Family Polyclinic Type I, Family Polyclinic Type II and Family Polyclinic Type II Branch facilities, where on-site testing was almost entirely absent.



Figure 86. Example of Rapid Urine Test Strips Multistix 10 SG (Siemens) – Not a Photo from the Survey



Figure 87. Example of Rapid Urine Test Strips Multistix 10 SG (Siemens) – Not a Photo from the Survey

4.4.5 Syphilis rapid diagnostic test (D9)

Rapid syphilis testing is an essential point-of-care diagnostic that supports the early detection and treatment of syphilis, particularly during pregnancy to prevent congenital syphilis and other adverse maternal and neonatal outcomes. The test can be performed by appropriately trained primary health care staff using a rapid diagnostic test without requiring laboratory infrastructure, enabling immediate diagnosis and treatment during the same patient visit. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:



Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey.

- ☐ 9% (31/362) were able to perform a rapid syphilis test on-site.
- ☐ 91% (331/362) could not perform a rapid syphilis test on-site.

The SARA assessment found that only 9% (31/362) of primary health care facilities were able to perform a rapid syphilis test on-site. Consequently, 91% (331/362) of facilities were unable to provide immediate syphilis testing, limiting opportunities for the timely diagnosis and treatment of syphilis, particularly among pregnant women attending antenatal care. Availability was highest in Multidisciplinary Central Polyclinics (37%; 29/78), while availability was almost absent in other facility types. Only 3% (2/73) of Family Polyclinic Type II facilities were able to perform rapid syphilis testing, and no Family Polyclinics (0/115), Family Polyclinic Type I facilities (0/72) or Family Polyclinic Type II Branches (0/24) had on-site testing capability. These findings indicate that onsite rapid syphilis testing was concentrated almost entirely in MCPs and was virtually absent in pre-reform and post-reform first-contact facilities.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	0	0%	115	100%
Multidisciplinary Central Polyclinic (n=78)	29	37%	49	63%
Family Polyclinic Type 1 (n=72)	0	0%	72	100%
Family Polyclinic Type 2 (n=73)	2	3%	71	97%
Family Polyclinic Type 2 Branch (n=24)	0	0%	24	100%
Grand Total (n=362)	**31**	**9%**	**331**	**91%**

Table 67: Ability to perform a rapid syphilis test on-site, by facility type

It should be noted, however, that this does not necessarily mean patients lack access to syphilis testing. The WHO SARA methodology assesses only tests that can be performed on-site and does not evaluate access through referral systems. WHO has selected rapid syphilis testing as a tracer indicator because it is a simple point-of-care test that can be performed by appropriately trained primary health care staff without laboratory infrastructure and provides immediate results to support same-day clinical decision-making. Expanding the availability of rapid syphilis tests would strengthen the early diagnosis and treatment of syphilis, particularly during antenatal care, reduce dependence on external laboratory services, and contribute to the prevention of congenital syphilis. Attention should be given to Family Polyclinics, Family Polyclinic Type I, Family Polyclinic Type II and Family Polyclinic Type II Branch facilities, where on-site testing was almost entirely absent.



Figure 88. Examples of Rapid Syphilis Tests – Not Photos from the Survey

4.4.6 Pregnancy rapid diagnostic test (D11)

Rapid urine pregnancy testing is a simple point-of-care diagnostic that supports the early confirmation of pregnancy, enabling timely antenatal care, appropriate clinical management and informed referral decisions. The test can be performed using a urine pregnancy test by appropriately trained primary health care staff without requiring laboratory infrastructure, providing results within minutes during a routine consultation. Under the WHO SARA methodology, a facility is awarded one point if it meets the following definition:

Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey.

- ☐ 2% (8/362) were able to perform a rapid urine pregnancy test on-site.
- ☐ 98% (354/362) could not perform a rapid urine pregnancy test on-site.

The SARA assessment found that only 2% (8/362) of primary health care facilities were able to perform a rapid urine pregnancy test on-site. Consequently, 98% (354/362) of facilities were unable to provide immediate pregnancy testing, limiting opportunities for the rapid confirmation of pregnancy and timely clinical decision-making during routine consultations. Availability was highest in Multidisciplinary Central Polyclinics (6%; 5/78), although coverage remained low. Only 3% (2/73) of Family Polyclinic Type II facilities and 4% (1/24) of Family Polyclinic Type II Branches were able to perform rapid urine pregnancy testing. No Family Polyclinics (0/115) or Family Polyclinic Type I facilities (0/72) had on-site testing capability. These findings indicate that rapid urine pregnancy testing is largely absent across all surveyed primary health care facilities.

Facility Type	Yes	%	No	%
Family Polyclinic (n=115)	0	0%	115	100%
Multidisciplinary Central Polyclinic (n=78)	5	6%	73	94%
Family Polyclinic Type 1 (n=72)	0	0%	72	100%
Family Polyclinic Type 2 (n=73)	2	3%	71	97%
Family Polyclinic Type 2 Branch (n=24)	1	4%	23	96%
Grand Total (n=362)	**8**	**2%**	**354**	**98%**

Table 68: Ability to perform a rapid urine pregnancy test on-site, by facility type

The indicator measures onsite testing capacity only and does not establish whether women could access pregnancy testing through pharmacies, laboratories, referral arrangements or other clinical pathways, as these sources of access were not assessed. Although the WHO SARA methodology assesses only tests that can be performed on-site and does not evaluate access through referral systems. WHO has selected rapid urine pregnancy testing as a tracer indicator because it is a simple, inexpensive point-of-care test that can be performed by appropriately trained primary health care staff without laboratory infrastructure and provides immediate results to support timely clinical decision-making. Expanding the availability of rapid urine pregnancy tests would strengthen early pregnancy confirmation, facilitate timely entry into antenatal care, reduce dependence on external laboratory services, and improve the efficiency of reproductive and maternal health services. Attention should be given to all primary health care facility types, where on-site testing was almost entirely absent.



Figure 89. Example of Rapid Pregnancy Tests – Not a Photo from the Survey

4.4.7 Diagnostic capacity final score (DO4)

The DO4 basic diagnostic capacity domain assesses the availability of six tracer indicators representing the minimum on-site diagnostic capacity required to support routine primary health care. The DO4 percentage score is calculated by dividing the number of tracer indicators present on the day of the visit by 6.

Formula:

$$\textbf{DO4} = \frac{D1 + D2 + D4 + D5 + D9 + D11}{6} * 100\%$$

where:
D1 = Haemoglobin rapid test
D2 = Blood glucose rapid test
D4 = Urine dipstick protein rapid test
D5 = Urine dipstick glucose rapid test
D9 = Syphilis rapid test
D11 = Urine rapid test for pregnancy

The final scores were as follows:

Basic Diagnostic Capacity (DO4)	National Level	Family Polyclinic	Multidisciplinary Central Polyclinic	Family Polyclinic Type 1	Family Polyclinic Type 2	Family Polyclinic Type 2 Branch
	(n = 362)	(n = 115)	(n = 78)	(n = 72)	(n = 73)	(n = 24)
D1) Haemoglobin	12%	16%	28%	0%	4%	0%
D2) Blood glucose	35%	33%	50%	31%	36%	4%
D4) Urine dipstick- protein	9%	8%	24%	1%	5%	0%
D5) Urine dipstick- glucose	10%	10%	24%	1%	5%	0%
D9) Syphilis rapid test	9%	0%	37%	0%	3%	0%
D11) Urine test for pregnancy	2%	0%	6%	0%	3%	4%
Average Score DO4	**13%**	**11%**	**28%**	**6%**	**9%**	**1%**

Table 69: SARA basic diagnostic capacity tracer indicator scores (DO4), by facility type

The national Basic Diagnostic Capacity (DO4) average score was 13%, indicating that the availability of essential point-of-care diagnostic tests across primary health care facilities in Uzbekistan was very limited. Readiness varied substantially between facility types. Multidisciplinary Central Polyclinics achieved the highest score (28%), more than double the national average, while Family Polyclinics scored 11%. Readiness was considerably lower in Family Polyclinic Type II facilities (9%) and Family Polyclinic Type I facilities (6%), with Family Polyclinic Type II Branches recording the lowest score (1%), indicating that very few essential point-of-care diagnostic tests were available at these lower-level facilities.

Performance varied across the six tracer diagnostics, although all demonstrated low availability. Rapid blood glucose testing was the most widely available indicator (35%), followed by rapid haemoglobin testing (12%), urine glucose testing (10%), rapid syphilis testing (9%), urine protein testing (9%), and rapid urine pregnancy testing (2%), which was almost entirely unavailable. Multidisciplinary Central Polyclinics consistently recorded the highest availability across every tracer indicator, whereas Family Polyclinic Type II Branches demonstrated little or no on-site diagnostic capacity for any of the tests assessed.

In general, the onsite availability of WHO-recommended essential onsite diagnostic tests was the weakest component of readiness across almost all programme areas. Fewer than 12% of facilities could perform simple point-of-care tests such as urine dipstick and haemoglobin colorimeter tests. Although the assessment did not evaluate the performance of Uzbekistan's centralized laboratory network, the WHO SARA methodology considers these basic tests an essential component of primary health care readiness to be available onsite. The approved diagnostic service-delivery model should specify which rapid tests are required onsite at each facility type and which are to be accessed through the laboratory and referral network.

4.5 Essential medicines (D05)

Essential medicines are fundamental to delivering effective primary health care and ensuring that common health conditions can be treated promptly and appropriately. The availability of essential medicines enables health care workers to provide timely treatment for acute and chronic diseases, support preventive and maternal health services, manage communicable and non-communicable diseases, and reduce avoidable morbidity and mortality. High availability of essential medicines is therefore a key indicator of facility readiness to deliver quality health services.

The D05 Essential Medicines domain assesses the availability of twenty-five Essential Medicine tracer items defined by the WHO SARA methodology. These medicines were selected from the WHO Model List of Essential Medicines (2013) to represent the minimum pharmaceutical capacity expected within primary health care facilities. The D05 percentage score is calculated by dividing the number of tracer medicines observed on the day of the assessment by 25

Formula:

$$\textbf{D05} = \frac{\textit{Number of WHO Essential Medicines Present}}{25} * 100\%$$

Where the twenty-five WHO Essential Medicines are:
M56) Amlodipine tablet or alternative calcium channel blocker
M33) Amoxicillin syrup/suspension or dispersible tablet
M2) Amoxicillin tablet
M71) Ampicillin powder for injection
M57) Aspirin cap/tab
M59) Beclomethasone inhaler
M55) Beta blocker (e.g. Bisoprolol, Metoprolol, Carvedilol, Atenolol)
M119) Carbamazepine tablet
M5) Ceftriaxone injection
M25) Diazepam injection
M53) Enalapril tablet or alternative ACE inhibitor e.g. Lisinopril, Ramipril, Perindopril

M94) Fluoxetine tablet
M72) Gentamicin injection
M10) Glipalamide tablet
M124) Haloperidol tablet
M51) Insulin regular injection
M24) Magnesium sulphate injectable
M50) Metformin tablet
M11) Omeprazole tablet or alternative such as Pantoprazole, Rabeprazole
M32) Oral rehydration solution
M22) Oxytocin injection
M13) Salbutamol inhaler
M14) Simvastatin tablet or other Statin e.g. Atorvastatin, Pravastatin, Fluvastatin
M54) Thiazide (e.g. Hydrochlorothiazide)
M36) Zinc sulphate tablets, dispersible tablets or syrup

The final scores were as follows:

WHO Essential Medicines (DO5)	National Level	Family Polyclinic	Multidisciplinary Central Polyclinic	Family Polyclinic Type 1	Family Polyclinic Type 2	Family Polyclinic Type 2 Branch
	(n = 362)	(n = 115)	(n = 78)	(n = 72)	(n = 73)	(n = 24)
M56) Amlodipine tablet or alternative calcium channel blocker	37%	32%	32%	47%	47%	17%
M33) Amoxicillin syrup/suspension or dispersible tablet	41%	42%	35%	39%	58%	13%
M2) Amoxicillin tablet	45%	48%	51%	36%	53%	13%
M71) Ampicillin powder for injection	27%	30%	27%	21%	36%	4%
M57) Aspirin cap/tab	47%	48%	42%	53%	55%	17%
M59) Beclomethasone inhaler	15%	13%	23%	13%	18%	0%
M55) Beta blocker (e.g. Bisoprolol, metoprolol, carvedilol, atenolol)	44%	41%	44%	56%	47%	25%
M119) Carbamazepine tablet	13%	1%	53%	7%	0%	0%
M5) Ceftriaxone injection	17%	21%	32%	6%	11%	0%
M25) Diazepam injection	1%	0%	4%	0%	1%	0%
M53) Enalapril tablet or alternative ACE inhibitor e.g. lisinopril, ramipril, perindopril	38%	38%	36%	42%	41%	17%
M94) Fluoxetine tablet	1%	0%	3%	0%	0%	0%

M72) Gentamicin injection	2%	2%	4%	0%	4%	0%
M10) Glipalamide tablet	2%	2%	4%	0%	4%	0%
M124) Haloperidol tablet	4%	5%	6%	4%	1%	0%
M51) Insulin regular injection	30%	22%	81%	17%	12%	4%
M24) Magnesium sulphate injectable	69%	66%	68%	72%	84%	33%
M50) Metformin tablet	41%	34%	40%	61%	40%	25%
M11) Omeprazole tablet or alternative such as pantoprazole, rabeprazole	51%	47%	51%	61%	53%	33%
M32) Oral rehydration solution	53%	60%	46%	50%	67%	13%
M22) Oxytocin injection	4%	4%	5%	3%	4%	0%
M13) Salbutamol inhaler	53%	49%	49%	61%	59%	42%
M14) Simvastatin tablet or other statin e.g. atorvastatin, pravastatin, fluvastatin	18%	13%	19%	22%	26%	4%
M54) Thiazide (e.g. hydrochlorothiazide)	20%	17%	22%	25%	21%	4%
M36) Zinc sulphate tablets, dispersible tablets or syrup	6%	4%	5%	6%	12%	0%
Average Score DO5 Domain score = Mean score of items as percentage i.e N/25*100	**27%**	**26%**	**31%**	**28%**	**30%**	**11%**

Table 70: SARA essential medicine tracer indicator scores (DO5), by facility type

The national WHO Essential Medicines (DO5) score was 27%, indicating that on average, 27% of the 25 SARA essential-medicine tracer items were available in surveyed PHC facilities on the day of assessment. Readiness varied relatively little between most facility types, with Multidisciplinary Central Polyclinics achieving the highest score (31%), followed by Family Polyclinic Type II facilities (30%), Family Polyclinic Type I facilities (28%) and Family Polyclinics (26%). Family Polyclinic Type II Branches recorded a substantially lower score (11%), indicating markedly weaker availability of essential medicines than other facility types.

Availability varied considerably across the 25 medicine tracer indicators. Magnesium sulphate injection (69%) demonstrated the highest national availability, followed by oral rehydration solution (53%), salbutamol inhalers (53%), omeprazole or an equivalent proton pump inhibitor (51%), aspirin (47%) and amoxicillin tablets (45%). However, the majority of essential medicines were available in fewer than half of facilities. Particularly low availability was observed for rapid-acting insulin (30%), ampicillin injection (27%), thiazide diuretics (20%), statins (18%), ceftriaxone injection (17%), beclomethasone inhalers (15%), carbamazepine (13%), zinc sulphate (6%), haloperidol (4%), oxytocin (4%), gentamicin injection (2%), glibenclamide (2%), diazepam injection (1%) and fluoxetine (1%). Family Polyclinic Type II Branches consistently recorded the lowest availability across almost all tracer medicines.

The findings demonstrate that the availability of WHO essential medicines remains a significant constraint to primary health care service readiness in Uzbekistan. While several medicines supporting maternal health, common childhood illnesses, cardiovascular disease and asthma were reasonably well represented, many medicines for emergency care, mental health, diabetes, infectious diseases and chronic disease management were unavailable in most facilities. Where these medicines are required under the approved service package, their absence limits facilities' readiness to provide the corresponding treatment.

Future investment should prioritise strengthening the procurement and distribution of essential medicines while ensuring reliable supply chains and stock management systems in accordance with the approved functions and service package of each PHC facility type. Particular attention should be given to increasing the availability of medicines for emergency care, non-communicable diseases, mental health and infectious diseases, especially within Family Polyclinic Type II Branches. Continued monitoring of medicine availability, together with strengthened forecasting and logistics management, will be essential to achieve more equitable access to essential medicines throughout the primary health care system.

5. RESULTS: SERVICE SPECIFIC AVAILABILITY AND READINESS

5.1 Family planning services (S7)

Key Findings

Facilities providing family planning services 85%

85% of PHC facilities visited provide family planning services.Availability was broadly maintained in Type II Family Polyclinics (90%) compared with pre-reform Family Polyclinics (91%), but was lower in Type I facilities (81%) and Type II Branches (63%).

Overall readiness to deliver family planning services 64%

Overall readiness of these facilities to deliver family planning services was 64%.Readiness was 67% in pre-reform Family Polyclinics, compared with 61% in Type I facilities, 60% in Type II facilities and 52% in Type II Branches.

Equipment readiness 96%

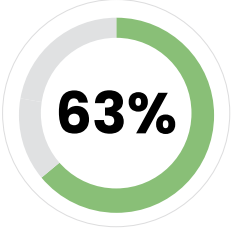
Equipment readiness scored 96%,based on the availability of the single tracer item—blood pressure apparatus. Equipment was therefore not the principal constraint identified by the assessment.

Staff and guidelines 75%

Staff and guidelines scored 75%, with 87% of facilities having at least one recently trained staff member in family planning during the previous two years, national family planning guidelines were observed in only 62%.

Medicines and commodities 20%

Medicines and commodities scored 20%, representing the principal constraint to service readiness. This is mainly because injectable contraceptives and IUCDs were widely available, whereas oral contraceptives, condoms, implants and emergency contraception were rarely available.Injectable contraceptives were available in 69% of facilities providing the service, and IUCDs in 69% as an auxiliary indicator. In contrast, oral contraceptive pills, male condoms, implants and emergency contraceptives were rarely available.



Type II Branches

The commodity gap was most pronounced in Type II Branches, where the medicines and commodities score was only 7%, despite high reported recent staff training. This substantially limited the range of family planning methods available at branch level.

Family planning services were widely available across Uzbekistan's primary health care network, with 85% of surveyed facilities providing family planning services. Availability was highest in Family Polyclinics (91%) and Family Polyclinic Type II facilities (90%), while coverage was lower in Multidisciplinary Central Polyclinics (79%), Family Polyclinic Type I facilities (81%), and particularly Type II Branch facilities (63%), reflecting differences in service delivery roles across the PHC network.

Family planning service readiness was calculated by taking the average of the three main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{D06 + D07 + D08}{3}$$

where:
D06 = Staff and guidelines domain score (75%)
D07 = Equipment domain score (96%)
D08 = Medicines and consumables domain score (20%)

$$\textbf{Service Readiness (\%)} = \frac{75\% + 96\% + 20\%}{3} = 64\%$$

Overall family planning service readiness averaged 64%, indicating that although most facilities offering family planning services possessed the basic infrastructure required to provide care, important gaps remained in the availability of essential commodities. Family Polyclinics recorded a score of 67%, compared with 61% in Type I Family Polyclinics, 60% in Type II Family Polyclinics and 52% in Type II Branches. The findings therefore show that Type II facilities largely maintained service availability but did not fully maintain the readiness level observed in pre-reform Family Polyclinics.

Equipment readiness was exceptionally high (96%), demonstrating that almost all facilities had the basic equipment required to deliver family planning services. Blood pressure apparatus—the single equipment tracer used for this service—was available in 97% of pre-reform Family Polyclinics, 98% of Type I facilities, 94% of Type II facilities and 87% of branches. This indicates that the tracer equipment item was not the principal constraint to family planning readiness. However, the score should not be interpreted as a comprehensive assessment of all equipment required for family planning services.

The staff and guidelines domain scored 75%. At least one staff member had received family planning training during the previous two years in 87% of facilities providing the service. Training coverage remained high across all facility types, including 83% of Type I facilities, 80% of Type II facilities and 93% of branches. Availability of national family planning guidelines was considerably lower, at 62% nationally. Guidelines were observed in 75% of pre-reform Family Polyclinics, compared with 50% of Type I facilities, 53% of Type II facilities and only 33% of branches. The lower readiness of post-reform facilities therefore reflects limited access to current clinical guidance rather than an absence of recently trained staff.

The availability of family planning medicines and commodities represented the principal constraint to service readiness, with a readiness score of only 20%. Injectable contraceptives were widely available (69%), and intrauterine contraceptive devices (IUCDs) were available in 69% of facilities as an auxiliary indicator.

In contrast, oral contraceptive pills were available in only 4–5% of facilities, male condoms in 3%, implants were almost universally unavailable, and emergency contraceptives were observed in only 1% of facilities. These findings indicate that although family planning services are widely offered, the range of contraceptive methods available at facility level remains limited.

Differences between facility types were relatively modest. Multidisciplinary Central Polyclinics achieved the highest overall readiness (68%), while Family Polyclinic Type I (61%), Type II (60%), and Type II Branch facilities (52%) recorded lower readiness, primarily because of lower availability of clinical guidelines and family planning commodities rather than deficiencies in equipment or trained staff.

Overall, the assessment demonstrates that family planning services are well established within Uzbekistan's primary health care system, with high service availability, well-trained staff and excellent equipment readiness. The principal opportunity for strengthening family planning service readiness lies in improving the availability of contraceptive commodities and expanding access to a broader range of modern contraceptive methods, thereby ensuring that women and couples have greater choice and more reliable access to essential family planning services. The commodity gap was most pronounced in Type II Branches, where the domain score was only 7%. Injectable contraceptives were available in 20% of branches, IUCDs in 27%, male condoms in 7%, and neither oral contraceptive pills nor implants were observed. Although 93% of branches had at least one recently trained staff member, the limited availability of guidelines and commodities substantially constrained their ability to provide a meaningful range of family planning options.

Type II Family Polyclinics also require attention. Although 90% reported offering family planning services, their overall readiness score was 60%, national guidelines were available in only 53%, and the commodity domain score was 20%. These findings indicate a gap between reported service availability and the inputs required to provide a consistent range of contraceptive methods.

The priority should be to align the contraceptive methods, commodities and clinical guidance available at each facility type with the approved national family planning service package. This does not necessarily require every method to be stocked at every facility. Each facility should, however, reliably provide the methods assigned to it and maintain clear referral arrangements for methods available elsewhere in the network.

Immediate attention should be given to Type II Branches and Type I Family Polyclinics, while ensuring that Type II Family Polyclinics are adequately equipped to function as the principal family planning service hubs. Action should include reliable forecasting and replenishment of contraceptive commodities, distribution of current national guidelines, routine stock monitoring and clearly defined referral pathways for methods not provided onsite.

Overall, family planning services were widely offered, and equipment and recent staff training were available in most facilities. The principal constraints were the limited range and availability of contraceptive commodities and the lower availability of national guidelines in the post-reform facility types.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S7) SERVICE AVAILABILITY % of facilities offering:	85%	91%	79%	81%	90%	63%
S7) Family planning services	85%	91%	79%	81%	90%	63%
S7_01) Provision of combined oral contraceptive pills	19%	21%	21%	8%	23%	29%
S7_02) Provision of progestin-only contraceptive pills	9%	7%	12%	3%	14%	8%
S7_03) Provision of combined injectable contraceptives	30%	33%	32%	24%	37%	8%
S7_04) Provision of progestin-only injectable contraceptives	51%	58%	53%	44%	52%	25%
S7_05) Provision of male condoms	8%	6%	12%	4%	11%	13%
S7_07) Provision of intrauterine contraceptive device	75%	78%	73%	72%	89%	33%
S7_08) Provision of implant	2%	0%	5%	0%	0%	8%
S7_09) Provision of cycle beads for standard days method	4%	2%	6%	6%	1%	4%
S7_10) Provision of emergency contraceptive pills	4%	3%	9%	1%	3%	4%
S7_12) Female sterilization	9%	8%	10%	6%	15%	4%
IN6) SERVICE READINESS = (DO6 + DO7 + DO8) / 3 % of facilities providing family planning services with tracer items on the day of the assessment	64%	67%	68%	61%	60%	52%
DO6) Staff and guidelines = (T2 + T3) / 2 Guidelines observed in service area.	75%	84%	80%	66%	67%	63%
T2) National guidelines on family planning	62%	75%	73%	50%	53%	33%

T3) Staff trained in family planning in last two years	87%	92%	87%	83%	80%	93%
DO7) Equipment = E5 Observed availability, reported functionality, and in service area or adjacent area.	96%	97%	98%	98%	94%	87%
E5) Blood pressure apparatus	96%	97%	98%	98%	94%	87%
DO8) Medicines and commodities = (M15 + M96 + M16 + M17) / 4 Observed in service area OR where routinely stored; in stock with at least one valid.	20%	21%	25%	18%	20%	7%
M15) Combined oestrogen progesterone oral contraceptive pills	5%	5%	8%	3%	3%	0%
M96) Progestin-only contraceptive pills	4%	6%	6%	2%	2%	0%
M16) Injectable contraceptives	69%	74%	77%	64%	73%	20%
M17) Male condoms	3%	1%	6%	3%	3%	7%
AUXILIARY INDICATORS % of facilities providing family planning services with:						
Other family planning commodities in stock						
M97) Combined oestrogen progesterone injectable contraceptives	22%	24%	29%	17%	24%	0%
M98) Progestin-only injectable contraceptives	50%	54%	53%	47%	52%	20%
M99) Implants	0%	0%	2%	0%	0%	0%
M108) Emergency contraceptive	1%	2%	0%	0%	0%	0%
M105) Intrauterine contraceptive device (IUCD)	69%	64%	69%	76%	83%	27%
Stock-outs (in past 3 months) Check stock records. Unavailability anytime in past three months due to unavailable stock						
M108_A) Implants	54%	58%	63%	45%	61%	7%
M109_A) Emergency contraceptive	53%	55%	61%	45%	65%	7%

Table 71: Family planning services (S7) readiness scores, by facility type

5.2 Antenatal care services (S8)

Key Findings

Facilities providing antenatal care (ANC) services **83%**

83% of primary health care facilities provided antenatal care (ANC) services.Availability was maintained in Type II Family Polyclinics (88%) compared with pre-reform Family Polyclinics (88%), but was lower in Type I facilities (79%) and Type II Branches (75%).

Overall ANC service readiness **55%**

Overall ANC service readiness to deliver this service averaged 55%, indicating that while ANC services were widely available, important readiness gaps remain.Readiness was broadly comparable in pre-reform Family Polyclinics (56%), Type I Family Polyclinics (53%) and Type II Family Polyclinics (54%), but substantially lower in Type II Branches (36%).

Equipment readiness **96%**

Equipment readiness was very high (96%), with almost all facilities having a functioning blood pressure apparatus.Equipment was therefore not the principal readiness constraint in Type I or Type II facilities, although availability was lower in branches (78%).

Staff capacity **73%**

Staff capacity was generally strong (73%),. While with 84% of facilities having at least one staff member trained in ANC during the previous two years, .national ANC guidelines were observed in only 62%, with particularly low availability in Type II Branches (22%).

Diagnostic capacity **10%**

Diagnostic capacity was the principal constraint, with a readiness score of only 10%, reflecting very limited availability of onsite haemoglobin and urine protein testing. It should be noted that the SARA methodology only scores this positively if the tests were available onsite on the day of the visit and does not score if they are part of central diagnostics.

Essential medicines and commodities **42%**

Essential medicines and commodities achieved moderate readiness (42%), with iron and folic acid tablets more widely available than tetanus toxoid vaccine.

Key opportunities for improvement

The principal opportunities to improve ANC readiness are to ensure timely access to haemoglobin and urine protein testing through the approved diagnostic pathway, strengthen the availability of ANC guidelines and essential medicines, and address the broader readiness gap in Type II Branches.

Antenatal care (ANC) services were widely available across Uzbekistan's primary health care network, with 83% of surveyed facilities providing ANC services. Availability was highest in Family Polyclinics and Family Polyclinic Type II facilities (both 88%), while somewhat lower availability was observed in Multidisciplinary Central Polyclinics (76%), Family Polyclinic Type I facilities (79%), and Type II Branch facilities (75%). These differences reflect the organisation of maternal health services across different levels of the primary health care system.

ANC service readiness was calculated by taking the average of the four main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{DO09 + DO10 + DO11 + DO12}{4}$$

where:
D009 = Staff and guidelines domain score (73%)
D010 = Equipment domain score (96%)
D011 = Diagnostics domain score (10%)
D012 = Medicines and consumables domain score (42%)

$$\textbf{Service Readiness (\%)} = \frac{73\% + 96\% + 10\% + 42\%}{4} = 55\%$$

Overall, ANC service readiness averaged 55%, indicating that although most facilities providing antenatal care possessed the basic infrastructure required to deliver routine services, important gaps remained. Pre-reform Family Polyclinics recorded a score of 56%, compared with 53% in Type I Family Polyclinics and 54% in Type II Family Polyclinics. These findings indicate that overall ANC readiness was broadly maintained in the two principal post-reform facility types. Type II Branches recorded a substantially lower score of 36%.

Equipment readiness was high (96%), demonstrating that facilities generally possessed the basic equipment required for routine antenatal care. Blood pressure apparatus, the single equipment tracer used for ANC readiness, was available in 97% of pre-reform Family Polyclinics, 98% of Type I facilities, 94% of Type II facilities and 78% of branches. Equipment was therefore not the principal constraint in Type I or Type II facilities, although the lower result in branches represents a relevant gap in routine blood pressure monitoring..

Staff capacity was generally strong, with a staff and guidelines readiness score of 73%. Most facilities (84%) reported that at least one health worker had received antenatal care training during the previous two years. However, national antenatal care guidelines were available in only 62% of facilities, suggesting opportunities to improve access to standardised clinical guidance and support adherence to national protocols. Training coverage was 90% in pre-reform Family Polyclinics, 72% in Type I facilities, 80% in Type II facilities and 67% in branches.

Diagnostic capacity represented the principal bottleneck to antenatal care readiness. The diagnostic readiness score was only 10%, reflecting the limited availability of point-of-care laboratory testing. Haemoglobin testing was available in only 11% of facilities and urine protein testing in 9%, despite both investigations being essential components of routine antenatal care for detecting maternal anaemia and hypertensive disorders. As discussed in the General Service Readiness chapter, these findings should be interpreted within the context of Uzbekistan's health system, where many laboratory investigations are intentionally centralised. Nevertheless, under the SARA approach these diagnostics are expected to be available at PHC level and therefore the results show a reduced score for facility readiness. Multidisciplinary Central Polyclinics recorded the highest diagnostic score, at 26%, compared with 10% in pre-reform Family Polyclinics, 1% in Type I facilities, 4% in Type II facilities and 0% in

branches. The results show that onsite haemoglobin and urine protein testing were almost entirely unavailable in the post-reform facility types. However, the SARA indicator measures onsite testing only and does not establish whether pregnant women could access these tests through laboratories, specimen referral or other diagnostic arrangements. The ANC service-delivery model should therefore specify where these tests must be available onsite and how timely access, return of results and clinical follow-up are ensured when testing is provided elsewhere.

The availability of essential antenatal medicines and commodities was moderate (42%). Iron tablets were available in 63% of facilities and folic acid tablets in 53%, supporting routine nutritional supplementation during pregnancy. In contrast, tetanus toxoid vaccine was available in only 11% of facilities,The largest medicines and commodities gap was observed in Type II Branches, where the domain score was only 20%. Iron tablets were available in 44% of branches, folic acid in 17%, and tetanus toxoid vaccine in none. These results indicate that branch readiness was constrained not only by diagnostics and clinical guidance but also by limited availability of basic ANC commodities.

Differences in readiness between facility types were relatively modest, although Multidisciplinary Central Polyclinics demonstrated the highest overall readiness (64%), largely because of greater diagnostic capacity and medicine availability. Family Polyclinic Type I facilities (53%), Family Polyclinic Type II facilities (54%), and particularly Type II Branch facilities (36%) recorded lower readiness scores, primarily reflecting limited access to diagnostics, clinical guidelines and essential medicines rather than deficiencies in equipment.

Overall, ANC service availability and readiness were broadly maintained in Type II Family Polyclinics compared with pre-reform Family Polyclinics. Type I facilities achieved a similar overall readiness score but recorded lower availability of guidelines and almost no onsite diagnostic capacity. The clearest implementation gap was concentrated in Type II Branches, where readiness was limited across equipment, guidelines, diagnostics and medicines.

The immediate priorities should be to: ensure that every facility providing ANC has the equipment, guidelines and medicines required under its assigned service package; define which ANC diagnostics must be available onsite at each facility type and establish reliable access arrangements for tests provided elsewhere; improve the availability of blood pressure apparatus, ANC guidelines, iron and folic acid in Type II Branches; and ensure timely access to tetanus vaccination in accordance with the approved immunisation delivery model. The objective should not be identical readiness scores across all facility types, but consistent capacity to deliver the ANC services assigned to each facility and timely access to services provided elsewhere in the network.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S8) SERVICE AVAILABILITY % of facilities offering:	83%	88%	76%	79%	88%	75%
S8) Antenatal care services	83%	88%	76%	79%	88%	75%
S8_01) Iron supplementation	71%	77%	58%	75%	78%	58%

S8_02) Folic acid supplementation	56%	60%	50%	58%	64%	29%
S8_04) Tetanus toxoid vaccination	10%	7%	19%	4%	12%	4%
S8_5) Monitoring for hypertensive disorder of pregnancy	61%	70%	51%	50%	70%	54%
IN7) SERVICE READINESS = (DO9 + DO10 + DO11 + DO12) / 4 % of facilities providing antenatal care services with tracer items on the day of the assessment	55%	56%	64%	53%	54%	36%
DO9) Staff and guidelines = (T4 + T5) / 2 Guidelines observed in service area.	73%	79%	81%	63%	73%	44%
T4) National guidelines on antenatal care	62%	67%	69%	54%	67%	22%
T5) Staff trained in ANC in last two years	84%	90%	93%	72%	80%	67%
DO10) Equipment = E5 Observed availability, reported functionality, and in service area or adjacent area.	96%	97%	98%	98%	94%	78%
E5) Blood pressure apparatus	96%	97%	98%	98%	94%	78%
DO11) Diagnostics = (D1 + D4) / 2 Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey. In the area where ANC tests are conducted or anywhere in the facility where laboratory testing is routinely conducted.	10%	10%	26%	1%	4%	0%
D1) Haemoglobin	11%	13%	29%	0%	3%	0%
D4) Urine dipstick- protein	9%	7%	24%	2%	5%	0%
DO12) Medicines and commodities = (M18 + M19 + M20) / 3 Observed in service area OR where routinely stored; in stock with at least one valid.	42%	38%	49%	49%	45%	20%
M18) Iron tablets	63%	61%	61%	72%	64%	44%
M19) Folic acid tablets	53%	48%	54%	68%	58%	17%
M20) Tetanus toxoid vaccine	11%	4%	31%	5%	13%	0%

Table 72: Antenatal care services (S8) readiness scores, by facility type

5.3 Immunization services (S10)

Key findings

Primary health care facilities providing routine immunization services **87%**

87% of primary health care facilities provided routine immunization services.Availability remained high in Type II Family Polyclinics (93%) and Type I Family Polyclinics (90%), compared with 97% of pre-reform Family Polyclinics.

Routine immunization service readiness **79%**

Routine immunization achieved the highest service readiness score (79%) of all programme areas assessed. Readiness was maintained in Type II Family Polyclinics (84%) compared with pre-reform Family Polyclinics (81%), but was lower in Type I facilities (69%).

Staff and guideline readiness **87%**

Staff and guideline readiness was very high (87%), with 96% of facilities having at least one staff member trained in immunization during the previous two years.while national immunization guidelines were observed in 77%.

Cold chain infrastructure was well established, with functional vaccine refrigerators available in 88% of facilities and temperature monitoring devices in 90%.However, only 66% maintained refrigerator temperatures within the required range and met the minimum cold-chain requirements.

Routine childhood vaccines **10%**

Routine childhood vaccines were widely available, and vaccine stock-outs during the previous three months were uncommon.although 10% of facilities reported an IPV stock-out during the previous three months.

Auto-disable syringes **24%**

Auto-disable syringes were observed in only 24% of facilities, representing the clearest injection-supply gap. Priorities are to strengthen temperature management, ensure the complete package of vaccines and injection supplies for every immunization session, and address the lower readiness observed in Type I facilities.

Type II Branches recorded low service availability (46%) and readiness (20%), but these results should be interpreted in the context of their predominantly scheduled, monthly immunization model. All required inputs should nevertheless be available whenever an immunization session is conducted.

Routine immunization services were widely available across Uzbekistan's primary health care network, with 87% of surveyed facilities providing routine immunization services. Availability was highest in Family Polyclinics (97%) and Family Polyclinic Type II facilities (93%), followed by Family Polyclinic Type I facilities (90%), while lower availability was observed in Multidisciplinary Central Polyclinics (78%) and Type II Branch facilities (46%). Routine immunization service readiness was calculated by taking the average of the three main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{DO16 + DO17 + DO18}{3}$$

where:
D016 = Staff and guidelines domain score (73%)
D017 = Equipment domain score (96%)
D018 = Medicines and consumables domain score (42%)

$$\textbf{Service Readiness (\%)} = \frac{87\% + 76\% + 76\%}{3} = 79\%$$

Overall, routine immunization demonstrated the highest service readiness of all programme areas assessed, achieving an overall readiness score of 79%. Readiness was highest in Multidisciplinary Central Polyclinics (85%) and Family Polyclinic Type II facilities (84%), followed by Family Polyclinics (81%), while Family Polyclinic Type I facilities (69%) and particularly Type II Branch facilities (20%) recorded lower readiness. It should be noted that these values should be taken with caution as the SARA methodology only awards points if service items are present on the day of these survey and Type II Branch facilities may not have been running active immunization activities on the day of the visit.

Staff capacity represented a major strength of the immunization programme. Staff and guideline readiness reached 87%, with 96% of facilities reporting that at least one health worker had received child immunization training during the previous two years. National child immunization guidelines were available in 77% of facilities, Availability was higher in Type II Family Polyclinics, at 88%, than in pre-reform Family Polyclinics (77%) and Type I facilities (71%). Guidelines were observed in only 27% of branches providing the service.
The equipment domain achieved a readiness score of 76%. Cold boxes or vaccine carriers were available in 92% of facilities, functional vaccine refrigerators in 88%, temperature-monitoring devices in 90%, immunization cards in 87%, and tally sheets in 79%.

Cold chain infrastructure was generally well established. Functional vaccine refrigerators were available in 88% of facilities providing immunization services, while 92% had cold boxes or vaccine carriers and 90% had refrigerator temperature monitoring devices. Immunization cards and tally sheets were also widely available, supporting appropriate documentation and monitoring of vaccination services. However, only 66% of facilities demonstrated that refrigerator temperatures had consistently remained within the recommended 2–8°C range during the previous 30 days, and 66% met all minimum WHO cold chain requirements. These findings suggest that while cold chain equipment is widely available, there is scope to strengthen cold chain management and monitoring. Performance was stronger in Type II Family Polyclinics, where 76% had adequate refrigerator temperatures and 75% met the minimum cold-chain requirements, compared with 63% and 62%, respectively, in Type I facilities.

Availability of routine childhood vaccines was generally high. Inactivated poliovirus vaccine (83%), oral polio vaccine (82%), measles vaccine (81%), DPT-Hib-HepB vaccine (81%), rotavirus vaccine (78%) and pneumococcal vaccine (77%) were available in most facilities providing immunization services. Human papillomavirus vaccine (50%) was less widely available. Vaccine stock-outs during the previous three months were uncommon, affecting 3% or fewer facilities for most vaccines, demonstrating a generally reliable vaccine supply system. Type II Family Polyclinics recorded availability of over 90% for all assessed childhood vaccines other than HPV.

Despite these strengths, several opportunities remain to further strengthen immunization services. Auto-disable syringes were available in only 24% of facilities, representing the most important equipment gap identified. In addition, strengthening cold chain performance to ensure that all vaccine refrigerators consistently maintain recommended storage temperatures would further improve vaccine quality assurance. Family Polyclinic Type I facilities demonstrated lower readiness than other facility types, primarily because of lower cold chain readiness and vaccine availability, suggesting that targeted investment in these facilities could further strengthen programme performance.

Overall, the assessment demonstrates that routine immunization is one of the strongest-performing programmes within Uzbekistan's primary health care system. High service availability, a well-trained workforce, robust vaccine availability and generally strong cold chain infrastructure provide a solid foundation for delivering high-quality immunization services. Future improvements should focus on strengthening cold chain performance, expanding the availability of essential immunization consumables such as auto-disable syringes, and addressing the specific readiness gaps in Type I Family Polyclinics and ensuring that Type II Branches have the complete set of inputs required for scheduled immunization sessions. The main implementation gaps were concentrated in Type I facilities, particularly in vaccine availability, cold-chain performance and auto-disable syringes. Type II Branches require assessment against their intended session-based delivery model rather than against expectations of permanent vaccine storage. The operational priority is to ensure that every scheduled immunization session is supported by the complete package of vaccines, injection supplies, cold-chain equipment, recording tools and trained personnel.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S10) SERVICE AVAILABILITY % of facilities offering:	87%	97%	78%	90%	93%	46%
S10) Routine immunization services	87%	97%	78%	90%	93%	46%
S10_07) Birth immunization	88%	97%	79%	90%	93%	46%
S10_08) Infant immunization	87%	96%	79%	90%	92%	46%
S10_09) Adult immunization	70%	72%	62%	85%	78%	25%

S10_10A) Daily immunization service	10%	11%	18%	6%	8%	0%
S10_10B) Weekly immunization service	41%	50%	44%	26%	51%	0%
S10_10C) Monthly immunization service	36%	35%	17%	58%	33%	46%
S10_10D) Quarterly immunization service	1%	0%	1%	0%	1%	0%
S10_10E) Other frequency immunization service	0%	0%	0%	0%	0%	0%
IN9) SERVICE READINESS = (DO16 + DO17 + DO18) / 3 % of facilities providing routine immunization with tracer items on the day of the assessment	79%	81%	85%	69%	84%	20%
DO16) Staff and guidelines = (T8 + T9) / 2 Guidelines observed in service area.	87%	88%	93%	82%	93%	50%
T8) National guidelines for child immunization	76%	77%	87%	71%	88%	27%
T9) Staff trained in child immunization in last two years	96%	98%	100%	94%	99%	73%
DO17) Equipment = (E14 + E15 + I21 + I22 + E39 + E49 + E41 + E42) / 8 Observed availability, reported functionality, and in service area or adjacent area.	76%	82%	86%	70%	82%	10%
E14) Cold box/vaccine carrier with ice packs	92%	98%	100%	91%	99%	18%
E15) Refrigerator	88%	97%	97%	78%	99%	9%
I21) Sharps container/safety box	80%	88%	93%	71%	85%	9%
I22) Auto-disable syringes	24%	28%	34%	15%	22%	0%
E39) Temperature monitoring device in refrigerator	90%	98%	98%	86%	99%	9%
E49) Adequate refrigerator temperature	66%	66%	80%	63%	76%	0%
E41) Immunization cards	87%	89%	93%	86%	96%	27%
E42) Immunization tally sheets	79%	90%	92%	68%	84%	9%

DO18) Medicines and commodities = (M28 + M29 + M30 + M93 + M92 + M142 + M143) / 7 Observed in service area OR where routinely stored; in stock with at least one valid.	76%	84%	87%	63%	88%	0%
M28) Measles vaccine	81%	91%	97%	66%	91%	0%
M29) DPT-Hib+HepB vaccine	81%	90%	93%	68%	94%	0%
M30) Oral polio vaccine	82%	92%	93%	66%	96%	0%
M93) Pneumococcal vaccine	77%	83%	89%	65%	91%	0%
M92) Rotavirus vaccine	78%	88%	84%	66%	93%	0%
M142) IPV (Inactivated Poliovirus Vaccine)	83%	92%	93%	72%	96%	0%
M143) HPV (Human Papillomavirus)	50%	52%	64%	38%	59%	0%
AUXILIARY INDICATORS % of facilities providing immunization services with:						
Stock-outs (in past 3 months) Check vaccine stock records. Inability to give vaccine anytime in past three months due to unavailable stock.						
M28_A) Measles vaccine	1%	1%	2%	0%	1%	0%
M29_A) DPT-Hib+HepB vaccine	1%	2%	2%	2%	0%	0%
M30_A) Oral polio vaccine	0%	1%	0%	0%	0%	0%
M31_A) BCG vaccine	4%	2%	5%	6%	6%	0%
M93_A) Pneumococcal vaccine	3%	6%	2%	2%	1%	0%
M92_A) Rotavirus vaccine	1%	2%	0%	0%	0%	0%
M142_A) IPV (Inactivated Poliovirus Vaccine)	10%	8%	11%	6%	16%	0%
M143_A) HPV (Human Papillomavirus)	2%	5%	3%	0%	1%	0%
Cold chain						
E47) Cold chain minimum requirements	66%	66%	80%	62%	75%	0%
E40) Energy source and power supply for vaccine refrigerator	92%	100%	100%	88%	100%	18%
E40_A) Types of power used for cold chain refrigeration	92%	100%	100%	88%	100%	18%

Table 73: Immunization services (S26) readiness scores, by facility type

5.4 Preventive and curative care for children under five (S11)

Key findings

Facilities providing preventive and curative services for children under five years of age  **88%**

88% of primary health care facilities provided preventive and curative services for children under five years of age.Availability was highest in Type II Family Polyclinics (95%), compared with 91% in pre-reform Family Polyclinics.

Overall service readiness  **49%**

Despite this, overall service readiness averaged 49%, reflecting important gaps in the resources required to deliver comprehensive child health services. Readiness was broadly maintained in Type II Family Polyclinics (51%) compared with pre-reform Family Polyclinics (54%), but was lower in Type I facilities (41%) and substantially lower in Type II Branches (16%).

Basic equipment readiness  **79%**

Basic equipment readiness was relatively high (79%), with most facilities having child weighing scales, length/height measuring equipment and growth charts.Child and infant scales, length or height measuring equipment and stethoscopes were available in more than 80% of facilities. However, equipment readiness was only 8% in Type II Branches, indicating a major gap in the basic tools required for routine child assessment.

Diagnostic capacity  **25%**

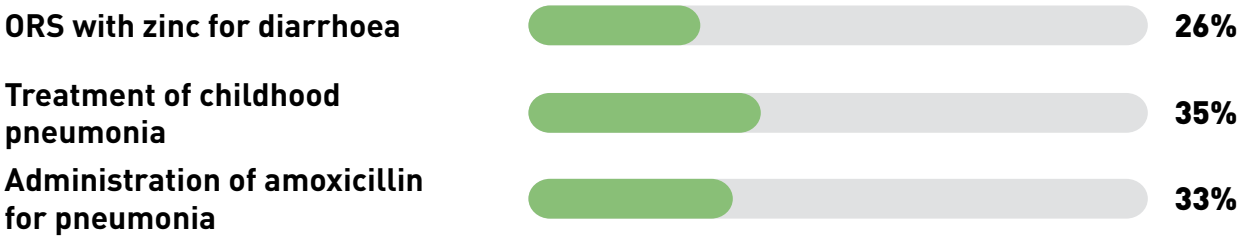
Diagnostic capacity (25%) and essential child medicines (28%) represented the principal constraints to child health service readiness.Haemoglobin testing was available in 12% of facilities, while ORS, amoxicillin and zinc were available in 57%, 42% and 7%, respectively.

Type II Branches recorded low service availability (46%) and readiness (20%), but these results should be interpreted in the context of their predominantly scheduled, monthly immunization model. All required inputs should nevertheless be available whenever an immunization session is conducted.

Diagnosis and treatment of malnutrition  **80%**

Growth monitoring  **75%**

While diagnosis and treatment of malnutrition (80%) and growth monitoring (75%) were widely available, services for managing common childhood illnesses such as pneumonia and diarrhoea were considerably less common.



Management of common childhood illnesses remained inconsistently available across the network. Only 26% of facilities provided ORS together with zinc for diarrhoea, 35% treated childhood pneumonia and 33% administered amoxicillin for pneumonia.

Priorities are to improve the availability of IMCI guidelines, essential child health medicines and the diagnostics required under each facility's service package, while addressing the broader equipment and commodity gaps in Type II Branches.

Preventive and curative health services for children under five years of age were widely available across Uzbekistan's primary health care network, with 88% of surveyed facilities providing child health services. Availability was highest in Family Polyclinic Type II facilities (95%) and Family Polyclinics (91%), while lower availability was observed in Multidisciplinary Central Polyclinics (82%) and Type II Branch facilities (71%), reflecting differences in service organisation across facility types.

Service readiness was calculated by taking the average of the four main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{DO19 + DO20 + DO21 + DO22}{4}$$

where:
D019 = Staff and guidelines domain score (63%)
D020 = Equipment domain score (79%)
D021 = Diagnostics domain score (25%)
D022 = Medicines and consumables domain score (28%)

$$\textbf{Service Readiness (\%)} = \frac{63\% + 79\% + 25\% + 28\%}{4} = 49\%$$

Despite broad service availability, overall child health service readiness averaged only 49%, indicating that many facilities lacked some of the essential inputs required to deliver comprehensive preventive and curative child health services. Readiness was highest in Multidisciplinary Central Polyclinics (57%), followed by Family Polyclinics (54%) and Family Polyclinic Type II facilities (51%), while Family Polyclinic Type I facilities (41%) and particularly Type II Branch facilities (16%) demonstrated substantially lower readiness.

Basic equipment for child health services was generally well established. Equipment readiness reached 79%, with child and infant weighing scales available in 87% of facilities, length or height measuring equipment in 84%, stethoscopes in 83%, and growth charts in 76%. Equipment readiness was maintained in Type II Family Polyclinics, which scored 87%, compared with 88% in pre-reform Family Polyclinics. Type I facilities recorded a

lower score of 72%. Type II Branches recorded only 8%, with particularly limited availability of child scales (12%), height-measurement equipment (6%), growth charts (6%) and thermometers (0%). This represents a clear gap in the basic inputs required for routine child assessment at branch level.

Staff capacity was moderate, with a staff and guidelines readiness score of 63%. National IMCI guidelines were available in 70% of facilities, while 67% reported that at least one staff member had received IMCI training during the previous two years. Growth monitoring guidelines were less widely available (43%), although 71% of facilities reported that staff had received growth monitoring training, suggesting that improving access to clinical guidance could further strengthen service quality. Type II Family Polyclinics performed comparatively well in this domain, with a score of 68%, exceeding the 66% recorded in pre-reform Family Polyclinics. Type I facilities scored 55%, reflecting lower availability of IMCI guidelines and lower recent IMCI training coverage. In branches, recent growth-monitoring training remained relatively high at 71%, but growth-monitoring guidelines were observed in only 12%.

Onsite diagnostic capacity and medicine availability represented the principal constraints to child health readiness. Diagnostic readiness averaged only 25%, with onsite haemoglobin testing available in just 12% of facilities and stool microscopy for parasite diagnosis in 39%. Essential child medicines and commodities also demonstrated low readiness (28%). Oral rehydration salts (57%), paracetamol syrup (45%) and amoxicillin (42%) were available in many facilities, while vitamin A capsules (10%), zinc preparations (7%) and co-trimoxazole suspension (2%) were rarely available. As discussed in the General Service Readiness chapter, the low availability of point-of-care diagnostics should be interpreted within the context of Uzbekistan's laboratory referral system The indicators measure onsite testing capacity only and do not establish whether facilities could access these tests through laboratories or referral arrangements. Diagnostic readiness was highest in MCPs, at 50%, reflecting their diagnostic role. Pre-reform Family Polyclinics scored 31%, compared with 14% in Type II facilities, 10% in Type I facilities and 0% in branches. The SARA indicators measure only tests that can be performed onsite with the required equipment and reagents available on the day of assessment; they do not measure access through laboratories or referral arrangements.

The assessment also identified opportunities to strengthen the management of common childhood illnesses. While 80% of facilities reported providing diagnosis and treatment for malnutrition and 75% conducted routine growth monitoring, only 26% reported providing oral rehydration salts together with zinc supplementation for childhood diarrhoea, and only 35% treated childhood pneumonia, with 33% administering amoxicillin for pneumonia. These findings suggest that although preventive child health services are well established, the management of common childhood illnesses could be further strengthened through improved availability of essential medicines, diagnostics and clinical support. Type II Branches recorded a medicines and commodities score of only 8%. Oral rehydration salts and paracetamol were each available in 18% of branches, amoxicillin in 12%, vitamin A in 6%, and zinc and deworming medicines in none.

Overall, child health service availability was maintained or improved in Type II Family Polyclinics, and their readiness remained close to that of pre-reform Family Polyclinics. The principal readiness constraints across the network were limited onsite diagnostics and low availability of essential medicines. Type I facilities require targeted strengthening of IMCI capacity, equipment and medicines, while Type II Branches show a broader implementation gap across equipment, diagnostics, clinical guidance and essential commodities.

Priorities should include: ensuring that each facility has the equipment, medicines and guidelines required under its assigned child health service package; improving the availability of ORS, zinc, amoxicillin and other medicines required for the management of common childhood illnesses; defining which child health diagnostics must be available onsite and establishing reliable access to tests provided elsewhere; and providing Type II Branches with the minimum package required for routine growth assessment, identification of childhood illness and appropriate referral.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S11) SERVICE AVAILABILITY % of facilities offering:	88%	91%	82%	88%	95%	71%
S11) Preventive and curative care for children under 5	88%	91%	82%	88%	95%	71%
S11_01) Malnutrition diagnosis and treatment	80%	84%	73%	78%	89%	54%
S11_02) Vitamin A supplementation	49%	52%	45%	51%	52%	25%
S11_03) Iron supplementation	60%	57%	58%	64%	68%	42%
S11_04) ORS and zinc supplementation	26%	25%	27%	22%	34%	8%
S11_05) Growth monitoring	75%	80%	71%	71%	88%	38%
S11_06) Treatment of pneumonia	35%	37%	45%	25%	38%	8%
S11_07) Administration of amoxicillin for the treatment of pneumonia in children	33%	33%	36%	29%	41%	8%
IN10) SERVICE READINESS = (DO19 + DO20 + DO21 + DO22) / 4 % of facilities providing services for children under 5 with tracer items on the day of the assessment	49%	54%	57%	41%	51%	16%
DO19) Staff and guidelines = (T10 + T11 + T12 + T13) / 4 Guidelines observed in service area.	63%	66%	65%	55%	68%	49%
T10) National guidelines for IMCI	70%	74%	75%	60%	75%	53%
T11) National guidelines for growth monitoring	43%	50%	39%	38%	52%	12%
T12) Staff trained in IMCI in last two years	67%	67%	73%	56%	72%	59%
T13) Staff trained in growth monitoring in last two years	71%	72%	72%	67%	74%	71%

DO20) Equipment = (E38 + E16 + E3 + E4 + E17) / 5 Observed availability, reported functionality, and in service area or adjacent area.	79%	88%	84%	72%	87%	8%
E38) Child and infant scale	87%	97%	91%	86%	94%	12%
E16) Length/height measuring equipment	84%	96%	89%	73%	94%	6%
E3) Thermometer	63%	65%	73%	57%	74%	0%
E4) Stethoscope	83%	90%	84%	83%	91%	18%
E17) Growth chart	76%	91%	84%	63%	80%	6%
DO21) Diagnostics = (D1 + D10) / 2 Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey. In area where tests for child health are carried out or anywhere in the facility where laboratory testing is routinely conducted.	25%	31%	50%	10%	14%	0%
D1) Haemoglobin	12%	14%	31%	0%	4%	0%
D10) Test parasite in stool (general microscopy)	39%	48%	69%	21%	23%	0%
DO22) Medicines and commodities = (M32 + M33 + M7 + M12 + M34 + M35 + M36) / 7 Observed in service area OR where routinely stored; in stock with at least one valid.	28%	30%	29%	25%	34%	8%
M32) Oral Rehydration Salts (ORS) sachets	57%	63%	55%	56%	67%	18%
M33) Amoxicillin 250 mg or 500 mg dispersible tablet or syrup/ suspension	42%	44%	39%	40%	57%	12%
M7) Co-trimoxazole syrup/ suspension	2%	3%	2%	0%	1%	0%
M12) Paracetamol syrup/suspension	45%	49%	38%	44%	55%	18%
M34) Vitamin A (retinol) capsules	10%	7%	9%	11%	16%	6%
M35) Albendazole or Mebendazole cap/tab	34%	42%	53%	19%	26%	0%
M36) Zinc sulphate tablets, dispersible tablets or syrup	7%	5%	8%	5%	13%	0%

Table 74: Paediatric services (S11) readiness scores, by facility type

5.5 HIV counselling and testing (S17)

Key findings

Facilities providing HIV counselling and testing services **40%**

40% of primary health care facilities provided HIV counselling and testing services, reflecting Uzbekistan's policy of concentrating HIV services in designated referral facilities.Availability was highest in MCPs (71%) and lower in pre-reform Family Polyclinics (46%), Type II Family Polyclinics (27%), Type I Family Polyclinics (21%) and Type II Branches (13%).

Overall service readiness **36%**

Overall service readiness averaged 36%, although this should be interpreted within the context of the national HIV service delivery model.Type II Family Polyclinics recorded the same readiness score as pre-reform Family Polyclinics (38%), while readiness was lower in Type I facilities (27%) and Type II Branches (21%).

Staff and guidelines **79%**

Staff and guideline readiness was relatively strong (79%), with 85% of facilities reporting that at least one staff member had received HIV counselling and testing training during the previous two years.

Confidential counselling facilities **58%**

Confidential counselling facilities were available in 58% of facilities providing HIV services.

On-site HIV diagnostic capacity (4%) and the availability of HIV prevention commodities (5%) were very limited.

Continued collaboration

Continued collaboration between primary health care facilities and specialised HIV/AIDS services remains essential to ensure timely referral, diagnosis and linkage to care.The priority is to clarify the role of each PHC facility type within the national HIV service-delivery model and ensure effective referral, linkage to testing and treatment, feedback and continuity of care between PHC facilities and specialised HIV services.

Uzbekistan delivers HIV prevention, diagnosis and treatment through a specialised network of HIV/AIDS centres and designated referral facilities. Consequently, lower service availability and readiness scores observed in primary health care facilities should not necessarily be interpreted as deficiencies in the health system, but rather as reflecting the organisation of national HIV services and referral pathways.

HIV counselling and testing services were available in 40% of surveyed primary health care facilities. Availability varied considerably by facility type, ranging from 71% of Multidisciplinary Central Polyclinics to 46% of Family Polyclinics, 27% of Family Polyclinic Type II facilities, 21% of Family Polyclinic Type I facilities, and 13% of Type II Branch facilities. This distribution is consistent with the concentration of HIV services within higher-level facilities that provide a broader range of specialised outpatient services.

Following the SARA methodology, HIV counselling and testing readiness was calculated by taking the average of the four main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{D032 + D033 + D034 + D035}{4}$$

where:
D032 = Staff and guidelines domain score (79%)
D033 = Equipment domain score (58%)
D034 = Diagnostics domain score (4%)
D035 = Medicines and consumables domain score (5%)

$$\textbf{Service Readiness (\%)} = \frac{79\% + 58\% + 4\% + 5\%}{4} = 36\%$$

Among facilities providing HIV counselling and testing, overall service readiness averaged 36%. Readiness was highest in Multidisciplinary Central Polyclinics (48%), followed by Family Polyclinics (38%) and Family Polyclinic Type II facilities (38%), while Family Polyclinic Type I facilities (27%) and Type II Branch facilities (21%) recorded lower readiness. Pre-reform facilities also demonstrated higher readiness than post-reform facilities (42% versus 31%).

Staff capacity represented the strongest component of HIV service readiness. The staff and guidelines domain achieved a readiness score of 79%, with 85% of facilities reporting that at least one staff member had received HIV counselling and testing training during the previous two years. National HIV counselling and testing guidelines were available in 73% of facilities, indicating that most providers had access to current clinical guidance. The staff and guidelines score was 80% in Type II Family Polyclinics, close to the 88% recorded in pre-reform Family Polyclinics. Type I facilities scored 60%, primarily reflecting the low availability of national guidelines, which were observed in only 33%. In Type II Branches, guidelines were observed in 67%, but only 33% had at least one recently trained staff member.

Visual and auditory privacy was available in 58% of facilities providing HIV counselling and testing. Privacy was available in 65% of Type II Family Polyclinics, compared with 62% of pre-reform Family Polyclinics and 47% of Type I facilities. None of the Type II Branches providing the service met the privacy tracer requirement. This represents an important quality and confidentiality gap, particularly in smaller first-contact facilities.

Confidential counselling facilities were available in 58% of facilities providing HIV counselling and testing services. While this demonstrates that many facilities have dedicated space for confidential counselling, further improvements in privacy could strengthen the quality of HIV testing and counselling services and encourage greater uptake of testing.

On-site diagnostic capacity was intentionally limited. Only 4% of facilities had HIV rapid diagnostic tests available on the day of the assessment. Similarly, male condoms were available in only 5% of facilities providing HIV counselling and testing services. Availability was recorded in 7% of MCPs, 5% of Type II Family Polyclinics and 33% of the small number of Type II Branches providing the service. No condoms were observed in pre-reform Family Polyclinics or Type I facilities. These findings are consistent with Uzbekistan's policy of concentrating HIV testing, prevention commodities and treatment services within specialised HIV/AIDS facilities and should therefore be interpreted within the context of the national HIV programme rather than as evidence of inadequate service provision at the health system level.

The very low diagnostic and commodity scores substantially reduced the overall readiness score. However, the SARA assessment measures only inputs available onsite on the day of assessment. It does not establish whether clients could access HIV testing, condoms or treatment through specialised HIV services, referral arrangements or other programme delivery channels. The results should therefore not be interpreted as evidence that these services were unavailable across the health system.

The national HIV service-delivery model should clearly define the role of each PHC facility type in counselling, testing, prevention, referral and follow-up. Where PHC facilities are expected to provide onsite testing or prevention commodities, the required diagnostic kits, condoms, trained staff and quality-assurance arrangements should be consistently available. Where testing and treatment are provided through specialised services, referral procedures, confirmation that clients reached the service, communication of results and continuity of care should be clearly organised.

Overall, Type II Family Polyclinics maintained readiness comparable to pre-reform Family Polyclinics among facilities providing HIV counselling and testing. The main PHC-level gaps were limited service availability, inadequate privacy in many facilities, and the near absence of onsite diagnostic tests and prevention commodities. Type I facilities require particular attention to guideline availability and privacy, while the intended role and minimum service package of Type II Branches should be clarified.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S17) SERVICE AVAILABILITY % of facilities offering:	40%	46%	71%	21%	27%	13%
S17) HIV counselling and testing	40%	46%	71%	21%	27%	13%
IN14) SERVICE READINESS = (DO32 + DO33 + DO34 + DO35) / 4 % of facilities providing hiv counselling and testing services with tracer items on the day of the assessment	36%	38%	48%	27%	38%	21%

DO32) Staff and guidelines = (T30 + T31) / 2 Guidelines observed in service area.	79%	88%	92%	60%	80%	50%
T30) National guidelines on HIV counselling and testing	73%	79%	96%	33%	80%	67%
T31) Staff trained in HIV counselling and testing in last two years	85%	96%	87%	87%	80%	33%
DO33) Equipment = I23 Observed availability, reported functionality, and in service area or adjacent area.	58%	62%	73%	47%	65%	0%
I23) Visual and auditory privacy	58%	62%	73%	47%	65%	0%
DO34) Diagnostics = D6 Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey. In area where tests for HIV are carried out or anywhere in the facility where laboratory testing is routinely conducted.	4%	0%	18%	0%	0%	0%
D6) HIV diagnostic capacity	4%	0%	18%	0%	0%	0%
DO35) Medicines and commodities = M91 Observed in service area OR where routinely stored; in stock with at least one valid.	5%	0%	7%	0%	5%	33%
M91) Male condoms	5%	0%	7%	0%	5%	33%

Table 75: HIV counselling and testing (S17) readiness scores, by facility type

5.6 Diabetes diagnosis and management (S22)

Key findings

Facilities providing diabetes diagnosis and management services — **87%**

87% of primary health care facilities provided diabetes diagnosis and management services.Availability was maintained in Type II Family Polyclinics (90%) compared with pre-reform Family Polyclinics (86%).

Overall diabetes service readiness — **54%**

Overall diabetes service readiness averaged 54%, indicating that while diabetes services were widely available, important readiness gaps remain. Readiness was broadly comparable in pre-reform Family Polyclinics (56%), Type I Family Polyclinics (52%) and Type II Family Polyclinics (54%), but lower in Type II Branches (33%).

Equipment readiness — **95%**

Equipment readiness was excellent (95%), with almost all facilities having blood pressure apparatus, adult weighing scales and height measuring equipment although equipment readiness was lower in Type II Branches (70%).

Staff and guidelines — **79%**

Staff and guideline readiness was relatively high (79%), with 92% of facilities reporting that at least one staff member had received diabetes training during the previous two years.while national diabetes guidelines were observed in 65%.

Diagnostic capacity — **18%**

Essential diabetes medicines — **26%**

Diagnostic capacity (18%) and essential diabetes medicines (26%) represented the principal constraints to diabetes service readiness.

Priorities



Priorities are to define the diagnostic and medicine package required at each facility type, ensure timely access to blood glucose and urine testing through onsite or referral arrangements, improve availability of current clinical guidelines, and strengthen the supply of medicines required for long-term diabetes management.

Diabetes diagnosis and management services were widely available across Uzbekistan's primary health care network, with 87% of surveyed facilities providing diabetes services. Availability was highest in Multidisciplinary Central Polyclinics (92%) and Family Polyclinic Type II facilities (90%), followed by Family

Polyclinics (86%), Family Polyclinic Type I facilities (82%), and Type II Branch facilities (75%). These findings indicate that diabetes care is well integrated within the primary health care system.

Diabetes service readiness was calculated by taking the average of the four main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{DO49 + DO50 + DO51 + DO52}{4}$$

where:
D049 = Staff and guidelines domain score (79%)
D050 = Equipment domain score (95%)
D051 = Diagnostics domain score (9%)
D052 = Medicines and consumables domain score (26%)

$$\textbf{Service Readiness (\%)} = \frac{79\% + 95\% + 18\% + 26\%}{4} = 54\%$$

Despite high service availability, overall diabetes service readiness averaged 54%, demonstrating that many facilities lacked some of the essential inputs required for comprehensive diabetes diagnosis and long-term management. Readiness was highest in Multidisciplinary Central Polyclinics (62%), followed by Family Polyclinics (56%), Family Polyclinic Type II facilities (54%), and Family Polyclinic Type I facilities (52%), while Type II Branch facilities (32%) demonstrated substantially lower readiness. Pre-reform facilities achieved slightly higher readiness than post-reform facilities (59% versus 46%).

Basic equipment for diabetes management was almost universally available. Equipment readiness reached 95%, with blood pressure apparatus available in 96% of facilities, adult weighing scales in 94%, and height measuring equipment in 96%. Equipment readiness was similarly high in pre-reform Family Polyclinics (99%), Type I facilities (95%) and Type II facilities (96%).Type II Branches recorded a lower equipment score of 70%. Blood pressure apparatus was available in 83% of branches, adult weighing scales in 61%, and height-measurement equipment in 67%. These gaps may limit routine assessment and monitoring where diabetes services are assigned to branch level. These findings indicate that facilities generally possess the equipment required for routine screening, cardiovascular risk assessment and clinical follow-up of people living with diabetes.

Staff capacity was another major strength. The staff and guidelines domain achieved a readiness score of 79%, with 92% of facilities reporting that at least one health worker had received diabetes training during the previous two years. National diabetes diagnosis and treatment guidelines were available in 65% of facilities, suggesting that expanding access to standardised clinical guidance could further support evidence-based management of diabetes at the primary health care level. Training coverage remained high in pre-reform Family Polyclinics (97%), Type I facilities (88%) and Type II facilities (89%).National diabetes diagnosis and treatment guidelines were observed in 65% of facilities. Availability was 77% in pre-reform Family Polyclinics and 74% in Type II Family Polyclinics, but lower in Type I facilities (53%) and particularly low in Type II Branches (17%). The principal staff-related gap was therefore access to current clinical guidance rather than recent training. Diagnostic capacity represented the principal constraint to diabetes service readiness. The diagnostics readiness score was only 18%, with on-site blood glucose testing available in 37% of facilities, urine protein testing in 9%, and urine ketone testing in 7%. While laboratory tests may be provided

through referral networks, these point-of-care tests are inexpensive, rapid, easy to carry out, and are widely recommended for routine diabetes management, and can substantially improve the early diagnosis and monitoring of diabetes within primary health care. Expanding access to onsite glucometers, test strips and urine dipsticks therefore represents a highly cost-effective opportunity to strengthen diabetes services at the PHC level. Diagnostic readiness was highest in MCPs, at 34%, consistent with the greater concentration of diagnostic capacity in these facilities. Pre-reform Family Polyclinics recorded a score of 15%, compared with 15% in Type II Family Polyclinics, 12% in Type I Family Polyclinics and 2% in Type II Branches.

The SARA indicators measure only tests that can be performed onsite with the required equipment and reagents available on the day of assessment. They do not establish whether patients could access these tests through laboratories, specimen referral or other diagnostic arrangements. The diabetes service-delivery model should therefore specify which tests must be available onsite at each facility type and how timely testing, return of results and clinical follow-up are ensured when diagnostics are provided elsewhere. Availability of essential diabetes medicines was also limited, with a medicines and commodities readiness score of 26%. Metformin was available in 45% of facilities and regular insulin in 33%, while gliclazide or glipizide (19%) and glipenclamide(4%) were much less commonly available. Insulin availability varied considerably between facility types, ranging from 14–24% in Family Polyclinics and Family Polyclinic Type II facilities to 86% in Multidisciplinary Central Polyclinics.

Overall, the assessment demonstrates that diabetes services are well established across Uzbekistan's primary health care system, supported by a well-trained workforce and excellent availability of basic clinical equipment. However, the quality and comprehensiveness of diabetes care are constrained by limited access to essential point-of-care diagnostics and medicines. Strengthening these relatively low-cost inputs would improve the early detection, routine monitoring and long-term management of diabetes and represents one of the greatest opportunities to enhance non-communicable disease services within primary health care. Priorities should include: idefining the diabetes diagnostic and medicine package assigned to each facility type; ensuring reliable access to blood glucose, urine protein and urine ketone testing through onsite or referral-based arrangements; improving the availability of current diabetes guidelines, particularly in Type I facilities and branches; ensuring continuous availability of medicines required under each facility's approved service package; and addressing the broader equipment, diagnostic and medicine gaps observed in Type II Branches.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S22) SERVICE AVAILABILITY % of facilities offering:	87%	86%	92%	82%	90%	75%
S22) Diabetes diagnosis and/or management	87%	86%	92%	82%	90%	75%
IN19) SERVICE READINESS = (DO49 + DO50 + DO51 + DO52) / 4 % of facilities providing diabetes services with tracer items on the day of the assessment	54%	56%	62%	52%	54%	33%

DO49) Staff and guidelines = (T43 + T44) / 2 Guidelines observed in service area.	79%	87%	81%	70%	82%	47%
T43) National guidelines for diabetes diagnosis and treatment	65%	77%	67%	53%	74%	17%
T44) Staff trained in diabetes diagnosis and treatment in last two years	92%	97%	94%	88%	89%	78%
DO50) Equipment = (E5 + E1 + E18) / 3 Observed availability, reported functionality, and in service area or adjacent area.	95%	99%	97%	95%	96%	70%
E5) Blood pressure apparatus	96%	97%	96%	98%	95%	83%
E1) Adult scale	94%	99%	97%	92%	97%	61%
E18) Measuring tape (height board/ stadiometer)	96%	100%	99%	95%	97%	67%
DO51) Diagnostics = (D2 + D5 + D20) / 3 Able to conduct the test on-site (in the facility) and functioning equipment and reagents needed to conduct the test are observed on-site on the day of the survey. In area where tests are carried out or anywhere in the facility where laboratory testing is routinely conducted.	18%	15%	34%	12%	15%	2%
D2) Blood glucose	37%	33%	54%	34%	38%	6%
D5) Urine dipstick- glucose	9%	7%	25%	2%	5%	0%
D20) Urine dipstick- ketones	7%	5%	24%	2%	2%	0%
DO52) Medicines and commodities = (M50 + M10 + M51 + M52 + M115) / 5 Observed in service area OR where routinely stored; in stock with at least one valid.	26%	23%	36%	29%	22%	11%
M50) Metformin cap/tab	45%	38%	42%	64%	42%	33%
M10) Glibenclamide cap/tab	4%	5%	7%	5%	2%	0%
M51) Insulin regular injectable	33%	24%	86%	17%	14%	6%
M52) Glucose 50% injectable	29%	37%	25%	29%	30%	0%
M115) Gliclazide tablet or glipizide tablet	19%	10%	18%	29%	24%	17%

Table 76: Diabetes (S22) readiness scores, by facility type

5.7 Cardiovascular disease (S23)

Key findings

Facilities providing cardiovascular disease (CVD) diagnosis and management services



86%

86% of primary health care facilities provided cardiovascular disease (CVD) diagnosis and management services. Availability was similar across facility types (FP 86%, MCP 91%, FP1 82%, FP2 90%) with the lowest availability in FP Type 2 Branch of 75%.

Overall cardiovascular disease service readiness



71%

Overall cardiovascular disease service readiness averaged 71%, representing one of the highest readiness scores among all programme areas assessed. Readiness was similar across facility types (FP 75%, MCP 70%, FP1 70%, FP2 74%) with the lowest readiness in FP Type 2 Branch of 42%.

Equipment readiness



91%

Equipment readiness was high (91%), with almost all facilities having blood pressure apparatus, adult weighing scales and stethoscopes apart from FP Type 2 Branch with 54%

Staff and guideline readiness



79%

Staff and guideline readiness was strong (79%), with 93% of facilities reporting that at least one staff member had received cardiovascular disease training during the previous two years apart from FP Type 2 Branch facilities reporting the lowest with 50%.

Availability of essential cardiovascular medicines



42%

Availability of essential cardiovascular medicines (42%) represented the principal constraint to service readiness – with FP Type 2 Branch reporting the lowest of 23%.

Priorities

Expanding access to essential antihypertensive and cardiovascular medicines would further strengthen the prevention and long-term management of cardiovascular disease at the primary health care level.

Cardiovascular disease (CVD) diagnosis and management services were widely available across Uzbekistan's primary health care network, with 86% of surveyed facilities providing cardiovascular services. Availability was highest in Multidisciplinary Central Polyclinics (91%) and Family Polyclinic Type II facilities (90%), followed by Family Polyclinics (86%), Family Polyclinic Type I facilities (82%), and Type II Branch facilities (75%). These findings demonstrate that cardiovascular disease prevention and management are well integrated into primary health care.

CVD service readiness was calculated by taking the average of the three main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{DO53 + DO54 + DO55}{3}$$

where:
D053 = Staff and guidelines domain score (79%)
D054 = Equipment domain score (91%)
D055 = Medicines and consumables domain score (42%)

$$\textbf{Service Readiness (\%)} = \frac{97\% + 91\% + 42\%}{3} = 71\%$$

Overall cardiovascular disease service readiness averaged 71%, representing one of the highest readiness scores among all programme areas assessed. Readiness was broadly consistent across the main facility types, ranging from 70% in Multidisciplinary Central Polyclinics and Family Polyclinic Type I facilities to 75% in Family Polyclinics, indicating a relatively uniform capacity to deliver cardiovascular care throughout the primary health care system. Type 2 Branch facilities had the lowest readiness scoring 42%. Pre-reform facilities demonstrated slightly higher readiness than post-reform facilities (73% versus 68%).

Staff capacity was a major strength of cardiovascular services. The staff and guidelines domain achieved a readiness score of 79%, with 93% of facilities reporting that at least one health worker had received training in the diagnosis and management of chronic cardiovascular conditions during the previous two years. National clinical guidelines were available in 66% of facilities, suggesting that wider dissemination of standardised guidance could further strengthen evidence-based management.
Basic equipment for cardiovascular care was almost universally available. Equipment readiness reached 91%, supported by the widespread availability of blood pressure apparatus (96%), adult weighing scales (94%) and stethoscopes (82%). These findings indicate that most facilities possess the essential equipment required for cardiovascular risk assessment, hypertension screening and routine follow-up of patients with chronic cardiovascular disease. Type 2 Branch facilities had the lowest availability of 54%.

Availability of essential cardiovascular medicines represented the principal constraint to service readiness. The medicines and commodities domain achieved a readiness score of 42%, considerably lower than the staff and equipment domains. Aspirin was available in 52% of facilities, beta blockers in 50%, ACE inhibitors in 41%, calcium channel blockers in 41%, and thiazide diuretics in only 21%. While these medicines were available in many facilities, increasing their availability would strengthen long-term management of hypertension and cardiovascular disease and improve continuity of care at the primary health care level. Type 2 branch had the lowest availability of 23%

Overall, the assessment demonstrates that cardiovascular disease services are well established across Uzbekistan's primary health care system, supported by a well-trained workforce and excellent availability of basic clinical equipment. The principal opportunity to strengthen cardiovascular services lies in improving the availability of essential medicines, thereby enabling more comprehensive long-term management of hypertension and other chronic cardiovascular conditions within primary health care.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S23) SERVICE AVAILABILITY % of facilities offering:	86%	86%	91%	82%	90%	75%
S23) Cardiovascular disease diagnosis and/or management	86%	86%	91%	82%	90%	75%
IN20) SERVICE READINESS = (DO53 + DO54 + DO55) / 3 % of facilities providing cardiovascular disease services with tracer items on the day of the assessment	71%	75%	70%	70%	74%	42%
DO53) Staff and guidelines = (T43 + T44) / 2 Guidelines observed in service area.	79%	88%	82%	69%	81%	50%
T45) National guidelines for diagnosis and treatment of chronic cardiovascular conditions	66%	78%	68%	53%	74%	17%
T46) Staff trained in diagnosis and management of chronic cardiovascular conditions	93%	99%	96%	86%	88%	83%
DO54) Equipment = (E4 + E5 + E1) / 3 Observed availability, reported functionality, and in service area or adjacent area.	91%	96%	91%	91%	95%	54%
E4) Stethoscope	82%	92%	77%	83%	92%	17%
E5) Blood pressure apparatus	96%	97%	97%	98%	95%	83%
E1) Adult scale	94%	99%	97%	92%	97%	61%
DO55) Medicines and commodities = (M53 + M54 + M55 + M56 + M57 + M50) / 6 Observed in service area OR where routinely stored; in stock with at least one valid.	42%	40%	39%	51%	45%	23%
M53) ACE inhibitor (e.g. enalapril, lisinopril, ramipril, perindopril)	41%	43%	38%	44%	45%	22%
M54) Hydrochlorothiazide tablet or other thiazide diuretic tablet	21%	19%	24%	25%	23%	6%
M55) Beta blocker (e.g. bisoprolol, metoprolol, carvedilol, atenolol)	50%	46%	46%	61%	52%	33%
M56) Calcium channel blockers (e.g. amlodipine)	41%	36%	35%	51%	52%	22%
M57) Aspirin cap/tabs	52%	54%	46%	58%	58%	22%
M50) Metformin cap/tabs	45%	38%	42%	64%	42%	33%

Table 77: Cardiovascular disease (S22) readiness scores, by facility type

5.8 Chronic respiratory disease (S24)

Key findings

Facilities providing chronic respiratory disease (CRD) diagnosis and management services  **80%**

80% of primary health care facilities provided chronic respiratory disease (CRD) diagnosis and management services. Availability was similar across facility types (FP 82%, MCP 91%, FP2 84%) with the lowest in FP1 68% and FP Type 2 Branch of 63%

Overall service readiness  **50%**

Overall service readiness averaged 50%, indicating that while respiratory services were widely available, important readiness gaps remain. Readiness was lowest in FP Type 2 Branch of 22%.

Staff and guideline readiness  **76%**

Staff and guideline readiness was relatively strong (76%), with 88% of facilities reporting that at least one staff member had received chronic respiratory disease training during the previous two years. FP Type 2 scored the lowest with 47%.

Respiratory-specific equipment readiness  **44%**

Respiratory-specific equipment readiness was limited (44%), reflecting low availability of peak flow meters and inhaler spacers. FP Type 2 scored the lowest with a score of 7%.

Essential respiratory medicines  **29%**

Essential respiratory medicines achieved only 29% readiness, with inhaled corticosteroids and emergency medicines particularly limited. FP Type 2 scored the lowest with 13%.

Priorities

Expanding access to respiratory-specific equipment and essential medicines would substantially strengthen the diagnosis and long-term management of asthma and other chronic respiratory diseases within primary health care.

Chronic respiratory disease (CRD) diagnosis and management services were widely available across Uzbekistan's primary health care network, with 80% of surveyed facilities providing chronic respiratory disease services. Availability was highest in Multidisciplinary Central Polyclinics (91%) and Family Polyclinic Type II facilities (84%), followed by Family Polyclinics (82%), Family Polyclinic Type I facilities (68%), and Type II Branch facilities (63%). These findings demonstrate that chronic respiratory disease services are generally integrated within primary health care, although availability varies between facility types.

CRD service readiness was calculated by taking the average of the three main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{D056 + D057 + D058}{3}$$

where:
D056 = Staff and guidelines domain score (76%)
D057 = Equipment domain score (44%)
D058 = Medicines and consumables domain score (29%)

$$\textbf{Service Readiness (\%)} = \frac{76\% + 44\% + 29\%}{3} = 50\%$$

Despite relatively high service availability, overall service readiness averaged only 50%, indicating that many facilities lacked the essential resources required for comprehensive respiratory care. Readiness was highest in Family Polyclinics (55%), followed by Multidisciplinary Central Polyclinics (53%) and Family Polyclinic Type II facilities (53%), while Family Polyclinic Type I facilities (45%) and particularly Type II Branch facilities (22%) recorded substantially lower readiness. Pre-reform facilities also demonstrated higher readiness than post-reform facilities (54% versus 45%).

Staff capacity represented the strongest component of chronic respiratory disease readiness. The staff and guidelines domain achieved a readiness score of 76%, with 88% of facilities reporting that at least one health worker had received training in the diagnosis and management of chronic respiratory disease during the previous two years. FP Type 2 Branch scored the lowest with a score 47%. National clinical guidelines were available in 65% of facilities, indicating that expanding access to standardised guidance could further support evidence-based respiratory care.

Respiratory-specific equipment represented the principal equipment constraint. Equipment readiness was only 44%, considerably lower than for other non-communicable disease programmes. Although 82% of facilities had stethoscopes available, only 30% had peak flow meters and 21% had inhaler spacers. FP type 2 Branch scored the lowest with 7%. These simple, low-cost devices are important for assessing airflow limitation, monitoring asthma control and supporting correct inhaler technique. Improving their availability would substantially strengthen the diagnosis and management of chronic respiratory diseases within primary health care.

Availability of essential respiratory medicines was also limited, with a medicines and commodities readiness score of 29%. Salbutamol inhalers were available in 58% of facilities and prednisolone tablets in 39%, while beclomethasone inhalers (17%), epinephrine injections (22%) and hydrocortisone injections (9%) were considerably less common. Increasing the availability of inhaled bronchodilators and inhaled corticosteroids would strengthen routine asthma management, while improved access to emergency medicines would enhance the treatment of acute exacerbations.

Overall, the assessment demonstrates that chronic respiratory disease services are well established within Uzbekistan's primary health care system, supported by a well-trained workforce. However, the quality and comprehensiveness of respiratory care are constrained by limited access to respiratory-specific equipment and essential medicines. Strengthening these relatively inexpensive inputs, particularly peak flow meters, inhaler spacers and essential inhaled medicines, would substantially improve the diagnosis, monitoring and long-term management of asthma and other chronic respiratory diseases at the primary health care level.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S24) SERVICE AVAILABILITY % of facilities offering:	80%	82%	91%	68%	84%	63%
S24) Chronic respiratory diseases	80%	82%	91%	68%	84%	63%
IN21) SERVICE READINESS = (DO56 + DO57 + DO58) / 3 % of facilities providing chronic respiratory disease services with tracer items on the day of the assessment	50%	55%	53%	45%	53%	22%
DO56) Staff and guidelines = (T47 + T48) / 2 Guidelines observed in service area.	76%	86%	77%	65%	81%	47%
T47) National guidelines for diagnosis and management of CRD	65%	80%	66%	47%	74%	13%
T48) Staff trained in diagnosis and management of CRD in last two years	88%	91%	87%	84%	89%	80%
DO57) Equipment = (E4 + E5 + E1) / 3 Observed availability, reported functionality, and in service area or adjacent area.	44%	49%	52%	37%	47%	7%
E4) Stethoscope	82%	91%	79%	80%	93%	13%
E19) Peak flow meter	30%	28%	56%	14%	30%	7%
E20) Spacers for inhalers	21%	29%	21%	18%	18%	0%

DO58) Medicines and commodities = (M53 + M54 + M55 + M57 + M50) / 5 Observed in service area OR where routinely stored; in stock with at least one valid.	29%	29%	29%	33%	31%	13%
M53) Salbutamol inhaler	58%	56%	54%	63%	62%	53%
M54) Beclomethasone inhaler	17%	15%	25%	14%	20%	0%
M55) Prednisolone cap/tabs	39%	39%	31%	55%	39%	13%
M57) Hydrocortisone injection	9%	11%	10%	6%	13%	0%
M50) Epinephrine injectable	22%	23%	24%	27%	23%	0%

Table 78: Chronic respiratory disease (S24) readiness scores by facility type

5.9 Cervical cancer prevention and control (S29)

Key findings

Cervical cancer screening services  **54%**

54% of primary health care facilities provided cervical cancer screening services, with highest levels available in Multidisciplinary Central Polyclinics (73%) and the lowest in FP Type 2 Branch (17%).

Overall service readiness  **53%**

Overall service readiness averaged 53% with highest levels available in Multidisciplinary Central Polyclinics (70%) and the lowest in FP Type 2 Branch (17%), indicating important gaps in the capacity to deliver cervical cancer screening.

Staff and guideline readiness  **78%**

Staff and guideline readiness was relatively strong (78%), with 91% of facilities reporting that at least one staff member had received cervical cancer training during the previous two years and 64% of facilities having national guidelines for cervical cancer present. FP Type 2 Branch scored the lowest with a score of 50%.

Basic examination equipment  **64%**

Basic examination equipment was available in only 64% of facilities providing cervical cancer prevention and control services. MCPs scored the highest with 82%. No equipment was observed in FP Type 2 Branch Facilities.

Screening consumables  **19%**

Availability of screening consumables was very limited (19%), with acetic acid for visual inspection rarely available apart from in MCPs which scored 47%.

Priorities

Expanding access to basic screening equipment and consumables would substantially strengthen cervical cancer prevention and support earlier detection of cervical cancer within primary health care.

Cervical cancer prevention and control services were available in 54% of surveyed primary health care facilities, making this one of the least widely available preventive health services assessed. Availability was highest in Multidisciplinary Central Polyclinics (73%), followed by Family Polyclinic Type II facilities (60%) and Family Polyclinics (57%), while substantially lower availability was observed in Family Polyclinic Type I facilities (32%) and Type II Branch facilities (17%). These findings suggest that cervical cancer screening remains concentrated within higher-level facilities rather than being universally available across the primary health care network.

Cervical cancer service readiness was calculated by taking the average of the three main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{D078 + D079 + D080}{3}$$

where:
D078 = Staff and guidelines domain score (78%)
D079 = Equipment domain score (64%)
D080 = Medicines and consumables domain score (19%)

$$\textbf{Service Readiness (\%)} = \frac{78\% + 64\% + 19\%}{3} = 53\%$$

Among facilities providing cervical cancer services, overall service readiness averaged 53%. Readiness was highest in Multidisciplinary Central Polyclinics (70%), followed by Family Polyclinics (57%) and Family Polyclinic Type II facilities (52%), while Family Polyclinic Type I facilities (43%) and Type II Branch facilities (17%) demonstrated substantially lower readiness. Pre-reform facilities also achieved higher readiness than post-reform facilities (64% versus 37%).

Staff capacity represented the strongest component of cervical cancer service readiness. The staff and guidelines domain achieved a readiness score of 78%, with 91% of facilities reporting that at least one health worker had received training in cervical cancer prevention and control during the previous two years. National clinical guidelines were available in 64% of facilities, indicating opportunities to strengthen access to standardised guidance and support consistent implementation of screening protocols. Family Polyclinics scored the highest with 88%. FP Type 2 Branch scored the lowest with a score of 50%.

Availability of basic examination equipment was moderate. Only 64% of facilities providing cervical cancer services had a functioning speculum available, despite this being an essential item for cervical examination and screening. Improving access to this basic equipment would enable more facilities to provide routine cervical cancer screening. MCPs scored the highest with 82% having basic equipment for this service. FP Type 2 Branch scored 0%.

Availability of screening consumables represented the principal constraint to service readiness. The diagnostics domain achieved a readiness score of only 19%, reflecting the very limited availability of acetic acid, which was present in just 19% of facilities providing cervical cancer services. MCPs scored the highest with 47% and FP Type 2 the lowest with 0%. Visual inspection with acetic acid (VIA) is a simple, evidence-based and low-cost screening method widely recommended for resource-constrained settings. Expanding the availability of acetic acid, together with appropriate equipment and trained providers, would substantially strengthen cervical cancer screening capacity within primary health care.

Overall, the assessment indicates that Uzbekistan has developed a trained workforce capable of supporting cervical cancer prevention, but service availability remains limited and many facilities lack the basic equipment and consumables required to provide screening. Expanding access to cervical cancer screening within primary health care, supported by reliable availability of speculums and screening consumables, represents an important opportunity to strengthen cancer prevention, promote earlier diagnosis and improve women's health outcomes.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S29) SERVICE AVAILABILITY % of facilities offering:	54%	57%	73%	32%	60%	17%
S29) Cervical cancer	54%	57%	73%	32%	60%	17%
IN26) SERVICE READINESS = (DO78 + DO79 + DO80) / 3 % of facilities providing cervical cancer services with tracer items on the day of the assessment	54%	57%	70%	43%	52%	17%
DO78) Staff and guidelines = (T60 + T61) / 2 Guidelines observed in service area.	78%	88%	82%	63%	82%	50%
T60) National guidelines for cervical cancer prevention and control	64%	82%	72%	43%	70%	0%
T61) Staff trained in cervical cancer prevention and control in last two years	91%	94%	91%	83%	93%	100%
DO79) Equipment = E44 Observed availability, reported functionality, and in service area or adjacent area.	64%	68%	82%	57%	64%	0%
E44) Speculum	64%	68%	82%	57%	64%	0%
DO80) Diagnostics = D37 Observed in service area OR where routinely stored; in stock with at least one valid.	19%	15%	47%	9%	9%	0%
D37) Acetic acid	19%	15%	47%	9%	9%	0%

Table 79: Cervical cancer prevention and control (S29) readiness scores by facility type

5.10 Minor outpatient surgical services (S25)

Key findings

Facilities providing basic outpatient surgical services **40%**

40% of primary health care facilities provided basic outpatient surgical services, reflecting Uzbekistan's policy of concentrating these services within designated referral facilities. MCPs scored the highest with 91%, FPs 50%, FP1 3%, FP2 14%, FP2 Branch 8%.

Overall service readiness **22%**

Overall service readiness averaged 22%, although this should be interpreted within the context of the national organisation of outpatient surgical services. Multidisciplinary Central Polyclinics demonstrated the highest readiness (40%), reflecting their role as the principal providers of outpatient surgical care within primary health care.

National guidelines **12%**

Basic surgical equipment **22%**

Essential surgical medicines and consumables **23%**

National guidelines (12%), basic surgical equipment (22%) and essential surgical medicines and consumables (23%) were all limited.

Basic surgical instruments **42%**

Basic surgical instruments were available in many designated facilities, but more specialised equipment and consumables were uncommon. MCPs scored the highest with 42%, FP1 and FP2 Branch scored 0%.

Considerations



The Ministry of Health may wish to review whether selected minor surgical procedures could be delivered more widely through primary health care to reduce patient travel and strengthen continuity of care. Where these services are provided, improving equipment, medicines and consumables would strengthen readiness.

Basic outpatient surgical services are not expected to be provided by all primary health care facilities in Uzbekistan. Instead, minor surgical procedures are intentionally concentrated within Multidisciplinary Central Polyclinics and selected Family Polyclinics. Consequently, lower service availability should not be interpreted as a weakness of the health system but rather as reflecting the national organisation of referral and outpatient surgical services.

Overall, 40% of surveyed facilities reported providing basic outpatient surgical services. Availability was highest in Multidisciplinary Central Polyclinics (91%), followed by Family Polyclinics (50%), while only 14% of Family Polyclinic Type II facilities, 8% of Type II Branch facilities, and 3% of Family Polyclinic Type I facilities provided these services. This distribution is consistent with the intended organisation of minor surgical care within the primary health care network.

Service readiness for basic outpatient surgical services was calculated by taking the average of the three main domains as follows:

Formula:

$$\textbf{Service Readiness (\%)} = \frac{DO59 + DO60 + DO61}{3}$$

where:
D059 = Staff and guidelines domain score (21%)
D060 = Equipment domain score (22%)
D061 = Medicines and consumables domain score (23%)

$$\textbf{Service Readiness (\%)} = \frac{21\% + 22\% + 23\%}{3} = 22\%$$

Among facilities providing outpatient surgical services, overall service readiness averaged 22%. Readiness was highest in Multidisciplinary Central Polyclinics (40%), followed by Family Polyclinics (28%) and Family Polyclinic Type II facilities (23%), while Family Polyclinic Type I and Type II Branch facilities recorded negligible readiness, reflecting their limited role in providing outpatient surgical care. Pre-reform facilities also demonstrated higher readiness than post-reform facilities (33% versus 10%).

Staff capacity represented an important constraint. The staff and guidelines domain achieved a readiness score of only 21%, with 30% of facilities reporting that at least one health worker had received training in Integrated Management of Emergency and Essential Surgical Care (IMEESC) during the previous two years. National IMEESC guidelines were available in only 12% of facilities, suggesting opportunities to strengthen clinical governance and support evidence-based delivery of minor surgical procedures.

Availability of basic surgical equipment was also limited. Equipment readiness averaged 22% with MCPs scoring the highest with 42% and FP1 and FP2 Branch scoring the lowest with 0%. Although several essential instruments were available, including surgical scissors (52%), needle holders (47%) and scalpels (47%). In contrast, retractors (14%), nasogastric tubes (6%), tourniquets (5%) and suction apparatus (7%) were rarely available, while no facilities reported the availability of adult or paediatric resuscitators. These findings indicate that the capacity to perform a broader range of outpatient procedures remains limited.

Essential surgical medicines and consumables demonstrated similarly low availability, with an average readiness score of 23%, with MCPs scoring the highest with 46% and FP1 and FP2 Branch scoring the lowest with 0%. Skin disinfectant was available in 50% of facilities, lidocaine in 33%, sutures in 22%, splints in 16%, and casting materials in only 14%. Improving the availability of these basic supplies would strengthen the capacity of designated facilities to provide safe outpatient surgical care.

Overall, the assessment found basic outpatient surgical services, including wound dressing, abscess drainage, minor burn management and suturing, were only available in 22% of surveyed facilities - consistent with the current service delivery model. The Ministry of Health may wish to review whether selected minor surgical procedures could be delivered more widely through primary health care to reduce patient travel and strengthen continuity of care. Where these services are provided, improving equipment, medicines and consumables, and clinical guidelines would strengthen readiness.

		Pre Reform Facilities		Post Reform Facilities		
SARA service specific availability and readiness indicators	**National Level**	**Family Polyclinic**	**Multidisciplinary Central Polyclinic**	**Family Polyclinic Type 1**	**Family Polyclinic Type 2**	**Family Polyclinic Type 2 Branch**
	n = 362	n = 115	n = 78	n = 72	n = 73	n = 24
S25) SERVICE AVAILABILITY % of facilities offering:	40%	50%	91%	3%	14%	8%
S25) Basic surgical services	40%	50%	91%	3%	14%	8%
S25_01) Incision and drainage of abscesses	30%	38%	76%	0%	8%	0%
S25_02) Wound care and dressing	19%	16%	62%	0%	5%	0%
S25_03) Management of minor burns	17%	22%	42%	0%	7%	0%
S25_04) Suturing of wounds	20%	18%	58%	0%	7%	0%
S25_05) Non-surgical treatment of fractures	10%	7%	38%	0%	0%	0%
S25_07) Male circumcision	11%	4%	42%	0%	1%	0%
S25_12) Removal of foreign bodies (throat, eye, ear or nose)	11%	9%	33%	0%	4%	0%
S25_10 Non-surgical treatment of dislocated joints	9%	5%	35%	0%	1%	0%
IN22) SERVICE READINESS = (DO59 + DO60 + DO61) / 3 % of facilities providing basic surgical services with tracer items on the day of the assessment	22%	28%	40%	0%	23%	0%
DO59) Staff and guidelines = (T49 + T50) / 2 Guidelines observed in service area.	21%	32%	32%	0%	20%	0%
T49) National guidelines for IMEESC	12%	25%	18%	0%	0%	0%
T50) Staff trained in IMEESC in last two years	30%	39%	46%	0%	40%	0%

DO60) Equipment = (E21 + E22 + E23 + E24 + E25 + E26 + E27 + E28) / 8 Observed availability, reported functionality, and in service area or adjacent area.	22%	28%	42%	0%	23%	0%
E21) Needle holder	47%	58%	79%	0%	60%	0%
E22) Scalpel handle with blades	47%	65%	75%	0%	50%	0%
E23) Retractor	14%	14%	35%	0%	10%	0%
E24) Surgical scissors	52%	70%	80%	0%	60%	0%
E25) Nasogastric tubes (10-16 FG)	6%	5%	21%	0%	0%	0%
E26) Tourniquet	5%	5%	15%	0%	0%	0%
E27) Adult and paediatric resuscitators	0%	0%	0%	0%	0%	0%
E28) Suction apparatus (manual or electric sucker)	7%	5%	27%	0%	0%	0%
DO61) Diagnostics = (M26 + M63 + M64 + M65 + M148 + M149) / 6 Observed in service area OR where routinely stored; in stock with at least one valid.	23%	25%	46%	0%	27%	0%
M26) Skin disinfectant	50%	65%	79%	0%	60%	0%
M63) Sutures (any type)	22%	19%	46%	0%	30%	0%
M64) Ketamine (injectable)	5%	4%	7%	0%	10%	0%
M65) Lidocaine (1% or 2% injectable)	33%	37%	52%	0%	50%	0%
M148) Splints for extremities	16%	18%	41%	0%	10%	0%
M149) Material for cast	14%	11%	48%	0%	0%	0%

Table 80: Minor outpatient surgical services (S25) readiness scores by facility type

6. DISCUSSION

Note on facility classification and legal context: The facility categories included in the SARA assessment reflect a transitional stage of Uzbekistan's ongoing health-sector reform. The principal legal framework comprises Presidential Decree No. PF-88 of 19 May 2025 on the continuation of healthcare reform and improvement of the system and principles of medical service delivery; Presidential Resolution No. PQ-185 of 19 May 2025 on additional measures to implement healthcare reforms; Cabinet of Ministers Resolution No. 382 of 19 June 2025 approving the guaranteed volumes of medical care financed from the State Budget in PHC facilities; and Cabinet of Ministers Resolution No. 384 of 20 June 2025 on implementation of the pilot project to improve the PHC delivery system. The current consolidated versions of these acts should be used, as they incorporate subsequent amendments.

Under this framework, existing Family Polyclinics, Family Doctor Points, affiliated facilities and Mahalla Medical Points are being reorganised into Family Polyclinics and their branches. Multidisciplinary Central Polyclinics are being transformed into consultative and diagnostic departments of the corresponding central district or city hospitals and will no longer have an attached population for PHC delivery. Their results are therefore retained in the SARA report for completeness and to reflect the facility structure at the time of assessment, but they are not treated as a future PHC investment category or as a direct comparator for Type I and Type II Family Polyclinics and Type II Branches. Pre-reform Family Polyclinics are used as the principal historical comparator for the reformed PHC facility types. The reform framework also provides for an interregional centralised laboratory service supporting Family Polyclinics and hospital departments.

Interpretation note: In this report, service availability refers to the proportion of surveyed facilities reporting that they offer a service. It should not be interpreted as a measure of population or geographic coverage. Readiness scores represent the average availability of specified tracer items among facilities providing the service; they do not represent the proportion of facilities possessing every required input.

1. PHC service availability is high, but readiness remains moderate and uneven. Most core PHC services were widely available across the surveyed facilities. However, the national General Service Readiness score was 57%, indicating that reported service availability did not consistently translate into the availability of all inputs required for effective and continuous service delivery.

Readiness was strongest for basic equipment, at 92%, infection prevention and control, at 78%, and basic amenities, at 77%. The weakest domains were onsite diagnostic capacity, at 13%, and essential medicines, at 27%. These results suggest that the next phase of PHC strengthening should focus less on the nominal presence of services and more on ensuring that facilities have the complete and sustainable package of inputs needed to deliver them.

The high basic equipment score should be interpreted as the average availability of the assessed tracer items. It does not mean that 92% of facilities had every required item, that all equipment was available in sufficient quantities for every consultation room, or that all equipment was in good condition. Field observations identified ageing, insufficiently maintained and inadequately distributed equipment in some facilities.

The national average also conceals substantial differences within the reformed PHC network. General Service Readiness was 57% in Type II Family Polyclinics, 54% in Type I Family Polyclinics and only 35% in Type II Branches, compared with 59% in pre-reform Family Polyclinics

2 The early performance of the reform differs substantially by facility type. The assessment was not designed as a formal impact evaluation and cannot attribute observed differences directly to the reform. Nevertheless, it provides important early evidence on how the reformed facility network is functioning.

Type II Family Polyclinics broadly maintained the overall readiness level recorded in pre-reform Family Polyclinics and achieved high service availability across most major programme areas. Family planning was available in 90% of Type II facilities compared with 91% of pre-reform Family Polyclinics; ANC in 88% of both facility types; child health services in 95% versus 91%; and diabetes services in 90% versus 86%. Routine immunization remained widely available, although at 93% in Type II facilities compared with 97% in pre-reform Family Polyclinics.

Type II facilities also recorded broadly comparable readiness for ANC, family planning, child health and diabetes and slightly stronger readiness for routine immunization. This pattern indicates that Type II Family Polyclinics are functioning as the principal PHC service hubs within the reformed network. Their effectiveness nevertheless remains constrained by limited diagnostic capacity, essential medicines, reliable utilities and selected service-specific inputs.

Type I Family Polyclinics demonstrated moderate overall readiness but lower performance than Type II facilities in diagnostics, IPC, access to some clinical guidelines and several service-specific domains. Their results indicate targeted implementation gaps rather than a uniform failure of the Type I model.

Type II Branches recorded substantially lower readiness across almost every domain. Although branches have a smaller scale and narrower role than Type I and Type II Family Polyclinics, several observed gaps concern fundamental requirements for safe and reliable first-contact care and cannot be explained solely by differences in service scope.

3 The investment case should adopt a branch-first, hub-linked and system-enabled approach. The findings support a sequenced investment strategy with three facility-focused phases:

- establishment of a minimum functional package in Type II Branches;
- targeted strengthening of Type I Family Polyclinics; and
- selective optimisation of Type II Family Polyclinics.

This sequencing should not imply that branches can be strengthened independently. Branches depend on their linked Type II Family Polyclinics for diagnostics not provided locally, distribution of medicines and consumables, clinical consultation, supportive supervision, referral coordination and digital information exchange.

The first phase should therefore be designed as a branch-first, hub-linked package. Investment in a branch should be accompanied by the specific improvements required at its linked Type II facility to make referral, diagnostics, supply distribution, supervision and communication operational.

Under a constrained financing envelope, the complete minimum package for priority branches and their essential hub linkages should be protected before the programme expands to Type I facilities. Type II investments that are not necessary to support branches can be undertaken subsequently as funding permits.

4 Type II Branches should be the first facility-level investment priority

Type II Branches recorded the weakest General Service Readiness results: 47% for basic amenities, 71% for equipment, 45% for IPC, 1% for diagnostics and 11% for essential medicines.

Several branch-level gaps concern fundamental operational requirements. Water was available on the assessment day in only 50% of branches, and only 54% had a functioning outpatient toilet. One third reported electricity interruptions lasting more than two hours per day, while none had a backup generator. Functioning cellular connectivity was available in only half of branches. Major gaps were also observed in hand hygiene, IPC materials, privacy, child health equipment, clinical guidelines and essential medicines.

The first phase of the investment case should establish a clearly defined minimum functional package for Type II Branches, covering:

- reliable electricity, water, sanitation and communications;
- minimum IPC and health-care waste-management arrangements;
- visual and auditory privacy;
- equipment and medicines required for the approved branch service package;
- predictable operating hours and an appropriate staffing model;
- digital access and referral communication;
- arrangements for maintenance, stock replenishment and technical support; and
- a functional service relationship with the linked Type II Family Polyclinic.

The package should establish common minimum standards but should not be a uniform construction and equipment package. The scale and composition of investment should take account of the population served, geographic isolation, workload, building condition, distance from the linked Type II facility and the services formally assigned to the branch.

Branches should not be expected to reproduce the complete diagnostic, pharmaceutical or specialist capacity of a Type II Family Polyclinic. They should, however, have the minimum resources required to provide their assigned first-contact functions safely and to initiate and complete referrals when care is needed elsewhere.

5. Type I Family Polyclinics should form the second investment phase. Type I Family Polyclinics recorded a General Service Readiness score of 54%. Their basic equipment score was relatively strong at 91%, but readiness was lower for basic amenities, at 73%, IPC, at 71%, diagnostics, at 6%, and essential medicines, at 28%.

Type I facilities also recorded lower availability of some clinical guidelines and lower readiness in child health and routine immunization than Type II facilities. Almost one third experienced electricity interruptions lasting more than two hours per day.

The second investment phase should therefore focus on targeted functional upgrading rather than comprehensive reconstruction or indiscriminate replacement of all equipment. Priorities should include:

- reliable utilities and appropriate electrical resilience;
- IPC, sanitation, privacy and waste management;
- diagnostics required under the Type I service package;
- essential medicines and consumables;
- access to current clinical guidelines and decision-support tools;
- replacement of obsolete or non-functional equipment;
- digital connectivity and referral functionality; and
- regular supportive supervision and consultation from the responsible Type II facility.

Facility-level investment packages should be based on the actual gaps identified rather than applying identical inputs to all Type I facilities.

6. Type II Family Polyclinics require selective optimisation of their hub functions. Type II Family Polyclinics recorded a General Service Readiness score of 57%, close to the 59% observed in pre-reform Family Polyclinics. Their equipment readiness was high, at 93%, and IPC readiness reached 79%. Service availability was also high across most programme areas.

However, their basic diagnostic capacity remained only 9%, while the essential medicines score was 30%. Gaps were also observed in continuity of electricity, safe health-care waste management, selected medicines and diagnostic consumables.

Investment in Type II facilities should therefore focus on the functions required for them to operate as effective PHC hubs:

- diagnostics appropriate to the Type II service package;
- specimen collection, transport and timely return of results;
- medicine and consumable distribution to linked facilities;
- clinical consultation and referral coordination;
- supportive supervision of branches;
- digital interoperability and referral tracking;
- maintenance and asset management; and
- continuity of critical services during electricity or connectivity interruptions.

Some of these investments must be included in Phase 1 where they are essential to make branch services functional. Type II investment should consequently be selective and function-driven rather than postponed entirely until the final phase.

7. Electricity and connectivity should be treated as core service-delivery infrastructure. During the week preceding the assessment, 42% of facilities reported electricity interruptions, and 17% experienced outages lasting more than two hours per day. Only 19% had a backup generator. Field observations also indicated that the presence of a generator did not always guarantee effective backup because some units were non-functional, inadequately sized or lacked reliable fuel or battery arrangements.

The report should not retain the estimate that approximately 400 additional generators of 30–100 kVA are required unless this is supported by a facility-level electrical load and engineering assessment. Generator capacity cannot be derived from the SARA data alone.

The investment case should instead finance facility-specific energy-resilience solutions based on service function, electrical load, frequency and duration of outages, cold-chain responsibilities and local grid reliability. Options may include:

- grid reinforcement;
- appropriately sized generators;
- solar photovoltaic systems;
- battery storage; or
- hybrid arrangements.

Priority should be given to facilities maintaining vaccine cold chains, Type II hubs supporting multiple linked facilities, high-workload facilities, and remote branches where restoration of grid supply may be delayed.

Functioning internet access was available in 90% of facilities on the assessment day. However, the indicator does not establish connection speed, stability or continuity during power interruptions. Digital health investment should therefore treat electricity, internet reliability, devices, equipment maintenance, user support and interoperable workflows as one operational package rather than as separate inputs.

8. WASH, IPC, privacy and waste management remain essential components of facility investment. Water was available on the assessment day in 88% of facilities overall but in only 50% of Type II Branches. A functioning outpatient toilet was available in 94% of facilities nationally but in only 54% of branches.

Only 44% of facilities had a dedicated staff toilet. However, compliance with national sanitary requirements should be assessed against the applicable facility size and patient-volume provisions; the SARA result alone does not establish that every facility without a separate staff toilet was non-compliant.

The report should also avoid treating every pit latrine as inadequate. A pit latrine with a slab may constitute improved sanitation if it is safe, functional and appropriately maintained. Immediate priority should be given to facilities without any functioning toilet, reliable water supply or hand-hygiene station, followed by facilities where sanitation capacity is insufficient for patient and staff volume.

Only 37% of facilities had both visual and auditory privacy. This is a system-wide quality gap affecting family planning, ANC, HIV counselling, adolescent health and other confidential services. Privacy should therefore be incorporated into the minimum functional package for each facility type.

Although the national IPC score was 78%, this average masks important weaknesses in infectious waste disposal, protected temporary storage, hand hygiene and branch-level readiness. Off-site removal alone does not demonstrate that waste was transported and treated safely. Investment should address:

- segregation at the point of generation;
- protected interim storage;
- sharps containers and infectious-waste bags;
- collection and transport arrangements;
- documented final treatment and disposal;
- clearly assigned responsibilities; and
- **routine monitoring of service providers.**

9. Emergency referral transport should be organised as a network function. The assessment found that 66% of facilities did not have their own emergency referral vehicle. However, ownership of a separate ambulance should not be considered a universal requirement for every PHC facility.

The more important finding is that, among the 238 facilities without their own vehicle, 134 also reported no access to a nearby emergency referral transport service. This represents a genuine network-level gap.

The investment case should focus on timely access rather than universal vehicle ownership and should assess:

- district-level pooled ambulance coverage;
- centralised dispatch and communication arrangements;

- expected response times;
- coverage of remote branches;
- referral protocols for obstetric, neonatal and other time-critical emergencies;
- vehicle maintenance and fuel arrangements; and
- digital recording and monitoring of referral completion.

10. The reformed network requires an explicit, facility-specific diagnostic model. Basic Diagnostic Capacity was the weakest General Service Readiness domain, with a national score of 13%. Within the reformed network, the score was 9% in Type II Family Polyclinics, 6% in Type I facilities and only 1% in branches.

Onsite blood glucose testing was available in 37% of facilities nationally. Availability was substantially lower for haemoglobin testing, at 12%; urine glucose testing, at 10%; urine protein and rapid syphilis testing, both at 9%; and rapid pregnancy testing, at 2%. The statement that fewer than 10% of facilities could perform blood glucose, urine dipstick and haemoglobin tests is therefore inaccurate and should not be retained.

The SARA indicators measure only tests that could be performed onsite with the necessary equipment and reagents available on the assessment day. They do not measure access through interregional laboratories, specimen referral or other diagnostic pathways.

The investment case should define:

- which tests must be available onsite in branches, Type I facilities and Type II facilities;
- which tests should be accessed through Type II facilities or centralised laboratories;
- specimen collection and transport arrangements;
- required turnaround times;
- electronic or documented return of results;
- notification and escalation of urgent findings;
- responsibility for clinical follow-up; and
- monitoring of completed diagnostic referrals.

The objective should not be to install every SARA tracer test in every PHC facility. It should be to align onsite capacity with the approved service package and ensure timely access to tests provided elsewhere.

11. Essential medicines require recurrent financing and supply-chain strengthening. The national Essential Medicines Readiness score was 27%, compared with 30% in Type II Family Polyclinics, 28% in Type I facilities and 11% in Type II Branches.

Medicine and commodity gaps were observed across family planning, ANC, child health and NCD services. Medicines such as magnesium sulphate, oral rehydration solution, salbutamol inhalers and omeprazole or an equivalent medicine were among the more frequently available tracer items. Nevertheless, most of the 25 assessed medicines were available in fewer than half of facilities.

The SARA assessment establishes whether tracer medicines were available on a particular day but does not determine whether their absence resulted from the approved service model, procurement, financing, forecasting, distribution, storage, prescribing rules or stock management.

The investment case should not assume that all 25 tracer medicines must be stocked at every facility type. It should establish a facility-specific medicines package aligned with assigned functions and include:

- quantification and forecasting;
- procurement and distribution;
- minimum and maximum stock levels;
- electronic inventory monitoring;
- redistribution between facilities;
- appropriate storage conditions;
- replenishment of diagnostic and treatment consumables; and
- recurrent budget requirements beyond the investment period.

Capital and recurrent costs should be clearly separated. Investment in buildings and equipment will not result in sustainable service improvement without predictable financing for medicines, reagents, maintenance, connectivity, utilities and supervision.

12. Programme-specific results reinforce the same cross-cutting priorities

Family planning and antenatal care

Family planning and ANC services were available in 85% and 83% of surveyed facilities, respectively, and were generally supported by recently trained staff and basic equipment.

Family planning readiness was primarily constrained by medicines and commodities, which scored only 20%. Injectable contraceptives and IUCDs were relatively widely available, while oral contraceptive pills, male condoms, implants and emergency contraceptives were rarely observed.

ANC readiness was primarily constrained by onsite diagnostics, with a domain score of 10%. Haemoglobin and urine protein testing were available onsite in only 11% and 9% of facilities providing ANC. Iron and folic acid were more widely available but remained incomplete, particularly in branches.

Investment should therefore combine contraceptive commodities, ANC medicines, clinical guidance, onsite or referral-based diagnostics, and clear referral and follow-up arrangements rather than treating each gap as a separate programme intervention.

Routine immunization

Routine immunization achieved the highest service readiness score, at 79%. Type II Family Polyclinics recorded readiness of 84%, compared with 81% in pre-reform Family Polyclinics, while Type I facilities recorded 69%.

Staff training, vaccines and most cold-chain equipment were generally available. However, only 66% of facilities maintained refrigerator temperatures within the required range and met the minimum cold-chain requirements. Auto-disable syringes were observed in only 24% of facilities.

Investment should protect the existing strengths of the programme while addressing temperature management, equipment maintenance, continuity of electricity, injection supplies and the lower vaccine readiness observed in Type I facilities.

Routine immunization in branches was predominantly organised through scheduled sessions. The low branch readiness score should therefore be interpreted in the context of this delivery model. Nevertheless, the complete package of vaccines, cold-chain equipment, injection supplies, recording tools and trained personnel must be available whenever an immunization session is conducted.

Child health and NCD services

Preventive and curative services for children under five were available in 88% of facilities, but overall readiness averaged 49%. Equipment readiness was relatively strong, while diagnostics scored 25% and medicines and commodities 28%.

Type II Family Polyclinics demonstrated comparatively strong service availability, including higher provision than pre-reform Family Polyclinics of malnutrition diagnosis and treatment, growth monitoring, ORS and zinc for diarrhoea, and amoxicillin for childhood pneumonia. Nevertheless, national availability of ORS, zinc, amoxicillin and other core child health medicines remained inconsistent.

Diabetes services were available in 87% of facilities and achieved overall readiness of 52%. Basic equipment and recent staff training were widely available, but the diagnostic domain scored only 9%, and medicines and commodities scored 26%. Onsite blood glucose testing was available in 11% of facilities providing diabetes services.

Comparable cross-cutting constraints were observed in cardiovascular and chronic respiratory disease services, including limited medicines, diagnostics and disease-specific equipment. These findings support shared PHC investment components for diagnostics, medicines, clinical guidance, equipment maintenance and referral rather than multiple parallel programme-specific equipment projects.

HIV counselling and testing

HIV counselling and testing services were reported by 40% of surveyed facilities. Among facilities providing the service, overall readiness averaged 36%.

Staff and guidelines represented the strongest domain, at 79%, while both visual and auditory privacy were available in only 58%. Onsite HIV diagnostic capacity and male condoms were observed in 4% and 5%, respectively.

The SARA assessment did not evaluate access through specialised HIV facilities or other programme channels. The findings should therefore be interpreted against the approved national HIV service-delivery model. The investment case should define the intended PHC role in counselling, risk assessment, confidential service provision, referral for testing, confirmation of referral completion, linkage to treatment and continuity of care.

Any statement that the low onsite availability of tests or prevention commodities is the intentional result of national policy should be supported by the relevant official policy or service-delivery document.

Basic outpatient surgical services

Basic outpatient surgical services were reported by a minority of surveyed facilities, and readiness among providers was low. However, the SARA findings alone do not establish which procedures should be available at each PHC facility type.

Before investment priorities are determined, the approved service package should specify:

- which basic outpatient procedures fall within PHC;
- which facility types should provide them;
- required competencies;
- equipment, medicine and IPC requirements;
- referral thresholds; and
- supervision and quality-assurance arrangements.

Facilities should then be strengthened only for the procedures formally assigned to them.

13. Workforce investment should focus on functionality, not training alone

Recent training coverage was relatively high across many programme areas. However, SARA measures whether at least one staff member received training during a specified period; it does not assess training quality, competency retention or application in clinical practice.

In several programmes, trained staff were present while guidelines, medicines, diagnostics or equipment were unavailable. Additional standalone training will therefore have limited impact unless accompanied by the complete service-delivery package.

Doctor recruitment and retention remain important constraints. Approximately 86% of approved doctor positions were filled nationally, compared with almost complete occupancy of nursing and other approved positions. Branches are particularly vulnerable because they had fewer than one generalist doctor per facility on average, meaning that the absence or departure of one staff member can disrupt service continuity.

Workforce investment should address:

- staffing norms aligned with workload and facility function;
- recruitment and retention in underserved locations;
- role clarity between branches and Type II hubs;
- competency-based training;
- supportive supervision;
- current guidelines and digital decision support;
- referral and remote consultation; and
- availability of the equipment, medicines and diagnostics required to apply acquired skills.

Staff occupancy rates should not be interpreted as evidence that staffing levels are adequate; they indicate only the proportion of approved posts that were filled.

14. SARA should serve as the baseline for investment monitoring

The assessment provides a national baseline but is subject to several methodological limitations. It is cross-sectional, records availability on or around the assessment day, measures onsite inputs rather than access through the wider service network, and does not assess the quality of clinical practice or establish the causes of identified gaps.

These limitations do not reduce its value for investment planning. They define how the results should be used: to identify priority facility types and readiness domains, establish measurable targets and monitor whether inputs become reliably available over time.

The investment proposal should include indicators covering:

- completion of the minimum functional package;
- continuity of electricity, water and connectivity;
- medicine and consumable availability;
- diagnostic turnaround time;
- referral completion and feedback;
- equipment functionality;
- service utilisation;
- staff availability and supportive supervision; and
- improvement in General and service-specific readiness scores.

A repeat SARA or streamlined facility-readiness assessment should be incorporated into the investment monitoring framework to determine whether implementation results in measurable and sustained improvements.

7. CONCLUSIONS

7.1 Summary of findings

The SARA methodology provides a robust national baseline for service availability and readiness but is designed as a rapid assessment tool. It measures the availability of services and tracer items present on the day of assessment rather than the quality, effectiveness or outcomes of care. Complementary assessments of service quality, clinical performance and patient experience would therefore provide valuable additional evidence to guide future health system strengthening.

The assessment demonstrates that Uzbekistan has established a comprehensive primary health care system with broad availability of essential services, a well-trained workforce and a strong foundation for delivering quality care. The principal challenge is no longer expanding service availability, but ensuring that facilities have the diagnostics, medicines, equipment and commodities required to deliver those services effectively.

Many of the most significant readiness gaps could be addressed through potentially modest investments (pending further cost-effectiveness analysis), including expanding access to basic point-of-care diagnostics, improving the availability of essential medicines and commodities, replacing obsolete equipment, strengthening digital connectivity, improving energy resilience, and continuing to strengthen WASH, infection prevention and control systems, ambulance referral capacity, and selected national clinical guidelines. These investments offer an opportunity to substantially improve primary health care readiness while supporting Uzbekistan's ongoing health sector reforms.

This assessment provides an important representative baseline of primary health care service availability and readiness in Uzbekistan. The findings identify priority areas for investment and provide an evidence base to support implementation of the national primary health care reform programme. Repeating the assessment at regular intervals will enable the Ministry of Health and its partners to monitor progress, evaluate the impact of reforms and ensure that future investments are directed towards areas of greatest need.

Uzbekistan has successfully established broad access to primary health care services; the next stage of reform should focus on strengthening facility readiness so that these services can be delivered consistently and to a high standard.

7.2 Priority actions and areas for investment

- ☐ **Backup power:** Develop a national programme to strengthen electrical resilience by prioritising appropriately sized backup generators for high-workload facilities and facilities with frequent power interruptions, together with sustainable fuel and maintenance arrangements based on historical power outage data. Only 19% (69/362) of facilities had a backup generator of which half (46% 32/69) were undersized of less than 3kVA. It is estimated that at least 400 diesel generators between 30kVa and 100 kVa are required.
- ☐ **Internet connectivity:** Achieve universal internet connectivity across all primary health care facilities, beginning with facilities identified without connectivity during the assessment and prioritising Multidisciplinary Central Polyclinics. Reliable electricity should be ensured to support uninterrupted digital health services. 10% (35/362) of facilities had no internet on the day of the visit. It is estimated that at least 100 GSM or satellite internet routers are required.

- ☐ **Water:** Investigate facilities that had no water supply at the time of the assessment. Prioritise investment in reliable water infrastructure, including rehabilitation of ageing pipework, improved water storage capacity and measures to ensure continuous water supply for infection prevention and clinical care. 12% (42/362) of facilities had no water at the time of the assessment. It is estimated that at least 120 complete water system rehabilitations are required.
- ☐ **Sanitation:** Increase the number of patient and staff toilets, prioritising high-volume facilities with low coverage (MCPs), then facilities where staff have no designated toilets, while progressively replacing pit latrines with improved sanitation facilities that comply with national standards including construction of accessible toilets for elderly patients, pregnant patients, and persons with disabilities. 6% (23/362) had no functioning toilets for clients, 30% (107/362) relied on pit latrines, 56% (204/362) did not have dedicated toilets for staff, and 34% (122/362) lacked sufficient toilets. It is estimated that at least 2,000 additional new toilets are required .
- ☐ **Emergency referral:** Strengthen emergency referral systems by improving access to dedicated referral transport or formal agreements with nearby ambulance services, particularly for facilities serving remote populations. 37% (134/362) of facilities had no access to emergency referral ambulances at either their own facility or one close by. It is estimated that at least 500 additional referral ambulances are required.
- ☐ **Basic equipment:** Replace ageing equipment, address remaining shortages of essential items and ensure that every consultation room is equipped with the basic equipment required for routine clinical care up to universal coverage. Self-reported equipment gaps by facilities include 4,860 adult scales, 4,532 infant scales, 3,996 height boards, 17,148 thermometers, 5,616 stethoscopes and 14,828 blood pressure monitors.
- ☐ **IPC:** Ensure universal access to disposable gloves, soap, chlorine-based disinfectant, safety boxes, and infectious waste bin bags. 7% (25/362) were missing soap, 14% (52/362) did not have latex gloves, 15% (56/362) were missing disinfectant, 3% (11/362) were missing sharps boxes. 3 months stock of IPC supplies should be always guaranteed in all facilities.
- ☐ **Healthcare waste management:** Phase out unsafe low-temperature health care waste incinerators in all health care facilities. Move to contracted sharps and infectious waste disposal with close environmental regulation of private sector service providers. 20% (74/362) of facilities were burning wastes. It is estimated that 300 facilities need support to transition from burning medical wastes to collection by private waste management services.
- ☐ **Onsite diagnostics:** Review the national diagnostic service delivery model to determine whether selected low-cost point-of-care tests - including blood glucose strips, haemoglobin and urine dipstick testing - could be moved to the primary health care setting to improve early diagnosis and clinical decision-making. 87% (315/362) of facilities were not carrying out simple diagnostic tests onsite. It is estimated that the six (6) WHO rapid tests are missing over 1,000 PHCs.
- ☐ **Essential medicines:** Review national essential medicine policies, procurement, financing, stock management and distribution systems to identify and address the underlying causes of low medicine availability, taking account of WHO recommendations for essential PHC level medicines. The facilities scored an average of 27% for the presence of the 25 WHO essential PHC medicines. Consider rolling out the full package to all PHCs.
- ☐ **Family planning and antenatal care:** Consider widening the availability of different contraceptive types and increasing access to essential antenatal diagnostics. Combined oral contraceptives were only available in 19% (69/362) of facilities, progestin only contraceptive pills were only available in 9% (33/362) of facilities and emergency contraceptive pills were only available in 4% (14/362) of facilities. Consider rolling out the full package to all PHCs.

- ☐ **Immunization:** Strengthen cold chain monitoring, ensure consistent refrigerator temperature control and achieve universal availability of auto-disable syringes to further improve immunization service quality and safety. 4% (12/317) of refrigerators were non-functional and 6% (17/317) of facilities offering immunization services did not have a refrigerator. It is estimated that at least 80 additional vaccine fridges are required. 37% (118/317) were missing continuous temperature monitors. It is estimated that at least 500 are required.
- ☐ **Child health:** Improve access to essential child medicines, point-of-care diagnostics and Integrated Management of Childhood Illness (IMCI) resources, particularly in Type I Family Polyclinics. The facilities scored an average of 28% for the presence of the 7 IMCI medicines. Consider rolling out the full package to all PHCs offering preventative and curative care to children under five.
- ☐ **HIV:** Continue strengthening referral pathways and collaboration between primary health care facilities and specialised HIV services, while expanding confidential counselling and HIV prevention services where appropriate.
- ☐ **NCD:** Strengthen primary health care management of non-communicable diseases through improved availability of point-of-care diagnostics, disease-specific equipment and essential medicines, with particular attention to lower-level facilities.
- ☐ **Basic outpatient surgical services:** Review the current outpatient surgical service delivery model and strengthen the readiness of facilities designated to provide basic outpatient surgical services through improved staff training, equipment and essential consumables. 63% (71/113) lacked surgical scissors, 65% (73/113) lacked skin disinfectant, 89% (100/113) lacked sutures, 97% (109/113) lacked ketamine (injectable), 78% (88/113) lacked lidocaine (1% or 2% injectable), 92% (104/113) lacked splints for extremities, and 96% (109/113) lacked material for casts. Consider equipping PHCs with WHO package of basic equipment and consumables.
- ☐ **Workforce training:** Continue investing in competency-based in-service training while ensuring that national clinical guidelines remain current, widely available and effectively implemented in routine clinical practice.
- ☐ **Medical workforce:** Develop targeted strategies to retain doctors, particularly in underserved areas.

Taken together, these recommendations provide a practical roadmap for strengthening primary health care readiness across Uzbekistan. Addressing the identified gaps would improve service quality, patient and staff safety, infection prevention and control, and continuity of essential health services, while supporting national priorities for digital transformation and health system resilience. Many of the recommended interventions - particularly improvements in diagnostics, essential medicines, water, sanitation and basic equipment - represent relatively low-cost investments with the potential to generate substantial improvements in service readiness and health outcomes. Implementing these recommendations would strengthen service readiness, improve quality of care, enhance patient and staff safety, and increase the resilience of the primary health care system to future public health emergencies and growing demands for digital health services.

APPENDICES

Appendix 'A' – SARA Survey Questionnaire

UNICEF Uzbekistan SARA Kobo Tool

Welcome to the UNICEF Uzbekistan SARA (Service Availability and Readiness Assessment) 2026. This data collection tool covers eight broad areas:

1. General Information
2. Staffing
3. Inpatient and observation beds
4. Infrastructure
5. Available services
6. Diagnostics
7. Medicines and commodities
8. Interviewer's observations

The facility agrees to share this information with the Ministry of Health and UNICEF to jointly identify priorities and support practical improvements in health services, strengthening safe and resilient health facilities.
☐ Agree ☐ Disagree

1.General Information

Assessor(s) Name(s): _____

01. Assessor phone number: _____

02. Date of assessment: _____ yyyy-mm-dd hh:mm

03. GPS location:

latitude (x.y °) _____

longitude (x.y °) _____

altitude (m) _____

accuracy (m) _____

04. Name of facility: _____

05. Region/Province: _____

06. District: _____

07. Type of healthcare facility:

☐ Family Doctor Point ☐ Family Polyclinic

☐ Family Polyclinic Type 1 ☐ Family Polyclinic Type 2

☐ Multidisciplinary Central Polyclinic ☐ Central District Polyclinic

☐ Other (describe)

If healthcare facility type is "Other", please describe: _____

11. Facility contact person name: _____

12. Facility contact person position: _____

13. Facility contact person phone number: _____

2. Staffing

201. Number of generalist (non-specialist) medical doctors:

202. Number of specialist medical doctors:

203. Number of non-physician clinicians/paramedical professionals:

204. Number nursing professionals:

205. Number pharmacists:

206. Number laboratory technicians (medical and pathology):

4. Infrastructure and Basic Equipment

404. » 4A. Communications

400. Does this facility have a functioning land line telephone?
☐ Yes ☐ No

401. Does this facility have a functioning cellular telephone coverage?
☐ Yes ☐ No

405. Does this facility have a functioning computer?
☐ Yes ☐ No

406. Is there access to email or internet within the facility today?
☐ Yes ☐ No

» 4B. Ambulance

407. Does this facility have a functional ambulance or other vehicle for emergency transportation for clients that is stationed at this facility or operates from this facility?
☐ Yes ☐ No

408. Does this facility have access to an ambulance or other vehicle for emergency transport for clients that is stationed at another facility or that operates from another facility in near proximity?
☐ Yes ☐ No

409. Is fuel for the ambulance or other emergency vehicle available today?
☐ Yes ☐ No

410. » 4C. Power Supply

411. Does your facility have electricity from any source (e.g. electricity grid, generator, solar, or other) including for stand-alone devices (EPI cold chain)?
☐ Yes ☐ No

412. What is the electricity used for in the facility?
☐ Only stand-alone electric medical devices/ appliances (e.g. epi cold room, refrigerator, suction apparatus, etc.)
☐ Only electric lighting and communications
☐ Electric lighting, communications, and 1 to 2 electric medical devices/ appliances
☐ All electrical needs of facility

413. What is the facility's main source of electricity?
☐ Central supply of electricity (e.g. national or community grid)
☐ Generator (fuel or battery operated generator)
☐ Solar power Other (specify)

Please specify the other source of electricity?

411a. Other than the main or primary source, does the facility have a secondary or backup source of electricity?
☐ Yes ☐ No

411b. What is the secondary source of electricity?
☐ Generator (fuel or battery operated generator)
☐ Solar power
☐ Other (specify)

Please specify the other source of electricity?

412. During the past 7 days, was electricity available at all times from the main or any backup source when the facility was open for services?
☐ Always available (no interruptions)
☐ Often available (interruptions of less than 2 hours per day)
☐ Sometimes available (frequent or prolonged interruptions of more than 2 hours per day)

413. Is the generator functional?
☐ Yes ☐ No
☐ Don't Know

414. Is there fuel and a charged battery available today?
☐ Yes ☐ No
☐ Don't Know

416. Is the solar system functional?
☐ Yes ☐ No
☐ Don't Know

414. » 4D. Water and Sanitation

417. On average, how many hours per day is this facility open?
☐ 4 hours or less
☐ 5 to 8 hours
☐ 9 to 16 hours
☐ 17 to 23 hours 24 hours a day

418a. What is the main source of water for the facility for DRINKING?
☐ Piped into facility
☐ Tubewell/borehole
☐ Protected dug well
☐ Unprotected dug well
☐ Protected spring
☐ Unprotected spring
☐ Rainwater collection
☐ Bottled water
☐ Tanker truck
☐ Surface water
☐ Other (specify)
☐ Don't know
☐ No water source

Please specify the other source of water?

418b. What is the main source of water for the facility for CLEANING and OTHER USES?
☐ Piped into facility
☐ Tubewell/borehole
☐ Protected dug well
☐ Unprotected dug well
☐ Protected spring
☐ Unprotected spring
☐ Rainwater collection
☐ Bottled water
☐ Tanker truck
☐ Surface water
☐ Other (specify)
☐ Don't know
☐ No water source

Please specify the other source of water?

419. Is water available from this source on facility premises?
☐ Yes, inside the facility
☐ Yes, within the ground of the facility
☐ No, outside the facility grounds

420. Are water quality checks carried out at least once a year and reports available with the facility?
☐ Yes ☐ No
☐ Don't Know

421a. Is there a functioning toilet on premises that is accessible for general outpatient use? OBSERVE THAT THE TOILET IS ACCESSIBLE (UNLOCKED OR KEY AVAILABLE) AND FUNCTIONING!
☐ Yes ☐ No

421b. What type of toilet is available?
☐ Flush toilet
☐ Pit latrine with slab
☐ Other toilet (specify)
☐ No facilities on premises

Please specify the other toilet type?

415. » 4E. Infection Control

422a. Does this facility have any guidelines on standard precautions for infection prevention?
☐ Yes, observed
☐ Yes, reported but not seen
☐ No

422b. Please take a photo of the document.

416. » 4F. Sterilization

423. Which functional sterilization equipment is available today? ONLY SELECT EQUIPMENT THAT IS FUNCTIONAL.
☐ Electric steam autoclave (pressure & wet heat)
☐ Electric dry heat sterilizer
☐ Electric boiler or steamer (no pressure)
☐ Non-electric autoclave
☐ Heat source for non-electric equipment
☐ Other sterilization equipment (specify)

Please specify the other type of sterilization equipment?

417. » 4G. Healthcare Waste Management

D7x. Which healthcare wastes are generated at this faciity?
☐ Sharps
☐ Infectious waste (e.g. soiled bandages / PPE)
☐ No healthcare wastes

424a. Is medical waste separated into GENERAL WASTE, INFECTIOUS WASTE, and SHARPS WASTE at all waste generation points?
☐ All ☐ Some
☐ None

424b. How does this facility carry out FINAL disposal of sharps waste (e.g. filled sharps boxes)?
☐ Burned in high temperature 2-chamber industrial incinerator (800-1000+° c)
☐ Burned in low temperature 1-chamber drum/ brick incinerator
☐ Open burning in pit
☐ Dumped without burning in open pit
☐ Dumped without burning in covered pit or pit latrine
☐ Stored in protected location and removed offsite
☐ Stored in unprotected location and removed offsite
☐ Other (specify)

Please specify the other FINAL disposal solution for sharps waste?

425. How does this facility carry out FINAL disposal of infectious medical waste other than sharps boxes (e.g. used bandages)?
☐ Burned in high temperature 2-chamber industrial incinerator (800-1000+° c)
☐ Burned in low temperature 1-chamber drum/ brick incinerator
☐ Open burning in pit
☐ Dumped without burning in open pit
☐ Dumped without burning in covered pit or pit latrine
☐ Stored in protected location and removed offsite
☐ Stored in unprotected location and removed offsite
☐ Other (specify)

Please specify the other FINAL disposal solution for infectious medical waste?

426. Is the incinerator functional today?
☐ Yes ☐ No
☐ Don't Know

427. Is fuel for the incinerator available today?
☐ Yes ☐ No
☐ Don't Know

418. » 4H. Supervision

430. When was the last time this facility received a supervision visit from the higher level (District Health Management Team or other)?
☐ This month
☐ In the last 3 months
☐ More than 3 months ago
☐ Don't know

431. During the supervision visit, what did the supervisor assess? (Select all that apply)
☐ Pharmacy (e.g. drug stock out, expiry, records, etc.)
☐ Staffing (e.g. staff available and training)
☐ Data (e.g. completeness, quality, and timely reporting)

» 4I. Basic Equipment

500. Which basic equipment used in the provision of outpatient services are available and functional in this facility today.
ONLY SELECT FUNCTIONAL EQUIPMENT
☐ Adult weighing scale
☐ Child weighing scale- 250 gram gradation
☐ Infant weighing scale – 100 gram gradation
☐ Measuring tape-height board
☐ Thermometer
☐ Stethoscope
☐ Blood pressure apparatus (may be digital or manual sphygmomanometer with stethoscope)
☐ Light source (flashlight acceptable)

501. At any time during the past 3 months has oxygen been unavailable for any reason?
☐ Yes ☐ No

419. » 4J. Infection Control Resources

600. Which basic resources/supplies used for infection control are available in the general outpatient area of this facility today?
☐ Functional handwasing station
☐ Hand-washing soap / liquid soap
☐ Alcohol based hand rub
☐ Disposable latex gloves
☐ General waste receptacle (pedal bin) with lid and plastic bin liner
☐ Infectious waste receptacle (pedal bin) with lid and plastic bin liner
☐ Sharps container ("safety box")
☐ Environmental disinfectant (e.g., chlorine, alcohol)
☐ Disposable syringes with disposable needles
☐ Auto-disable syringes

601. Are functioning hand hygiene stations with running water and soap available at all points of patient care?
☐ All ☐ Some ☐ None

602. Is the facility being cleaned on a daily basis?
☐ Yes ☐ No

603. Are cleaning staff supplied with personal protective equipment?
☐ Yes ☐ No

5. Available Services

600. Which primary health services are offered by this facility?
☐ A) Reproductive, maternal and newborn health services
☐ B) Immunization services
☐ C) Child and adolescent health services
☐ D) Communicable disease services
☐ E) Non-communicable diseases
☐ F) Surgical services
☐ Other services

601. What other services are offered by this facility?

420. » A. Reproductive, maternal and newborn health

650. Which reproductive, maternal and newborn health services are offered by this facility?
☐ i) Family planning services
☐ ii) Antenatal care services
☐ iii) Prevention of mother-to-child transmission of HIV
☐ iv) Obstetric and newborn care services (including normal delivery, basic emergency obstetric care, and/or comprehensive emergency obstetric care)
☐ v) Cesarean section
☐ Other (specify)

651. What other reproductive, maternal and newborn health services are offered by this facility?

» » i) Family planning services

701. Does this facility provide or prescribe any of the following modern methods of family planning?
☐ Combined estrogen progesterone oral contraceptive pills
☐ Progestin-only contraceptive pills
☐ Combined estrogen progesterone injectable contraceptives
☐ Progestin-only injectable contraceptives
☐ Male condoms
☐ Intrauterine contraceptive device (IUCD)
☐ Implants
☐ Cycle beads for standard days method
☐ Emergency contraceptive pills
☐ Female sterilization

703. Which documents are available in the facility today?
☐ National family planning guidelines
☐ Family planning check-lists or job aids

704a. Have staff received any family planning training in the last two years?
☐ Yes ☐ No

704b. Have staff received any training in adolescent sexual and reproductive health in the last two years?
☐ Yes ☐ No

705. Does this facility stock contraceptive commodities (contraceptive pills / injectables / condoms / implants) at this service site?
☐ Yes ☐ No

706. Please visit the dispensary and note any products that are EXPIRED.
☐ Combined estrogen progesterone oral contraceptive pills
☐ Progestin-only contraceptive pills
☐ Combined estrogen progesterone injectable contraceptives
☐ Progestin-only injectable contraceptives
☐ Male condoms
☐ Female condoms
☐ Implant (e.g. levonorgestrel, etonogestrel)
☐ Emergency contraceptive pills (e.g. levonorgestrel tablet, ulipristal acetate tablet, mifepristone tablet 10-25 mg)
☐ Intrauterine contraceptive device (IUCD)

707. Please visit the dispendary and note any STOCK OUT in the last 3 months.
☐ Female condoms
☐ Implant (e.g.levonorgestrel, etonogestrel)
☐ Emergency contraceptive pills (e.g. levonorgestrel tablet, ulipristal acetate tablet, mifepristone tablet 10-25 mg

421. » » ii) Antenatal care services

801. Which antenatal care services are provided?
☐ Iron supplementation
☐ Folic acid supplementation
☐ Tetanus toxoid immunization
☐ Monitoring for hypertensive disorder of pregnancy

802. Which antenatal care services documents are available?
☐ National antenatal care guidelines
☐ Any antenatal care check-lists and/or job-aids

803. Have staff received any antenatal care training in the last two years?
☐ Yes ☐ No

422. » » iii) Prevention of mother-to-child transmission of HIV

901. Which prevention of mother-to-child transmission of HIV services are provided?
☐ Provide HIV counselling and testing services to HIV positive pregnant women for prevention of mother-to-child transmission of HIV
☐ Provide HIV counselling and testing services to infants born to HIV positive pregnant women for prevention of mother-to-child transmission of HIV

902. Which prevention of mother-to-child transmission of HIV documents are available?
☐ National guidelines for prevention of mother-to-child transmission of HIV
☐ Guidelines for infant and young child feeding counselling

903. Have staff received any training in prevention of mother-to-child transmission of HIV in the last two years?
☐ Yes ☐ No

904. Is the prevention of mother-to-child transmission of HIV service room or area a private room/area with auditory and visual privacy?
☐ Auditory privacy only
☐ Visual privacy only
☐ Both auditory and visual privacy
☐ No privacy

423. » B. Immunization

1102. Which immunization services are provided?
☐ Infant vaccines (under 1 year)
☐ Child vaccines (over 1 year)
☐ Adolescent/adult vaccines (e.g. HPV, tetanus, flu)

1103. How often does this facility offer routine full child immunization services at the facility?
☐ Daily
☐ Weekly
☐ Monthly
☐ Quarterly
☐ Other frequency (specify)
☐ Never

Please specify the other frequency?

1105. Do you have the national guidelines for routine child immunization available in this facility today? ASK TO SEE A COPY
☐ Yes ☐ No

1106a. Which trainings in child immunization services have staff received in the last two years?
☐ Immunization service delivery (Immunization in practice or any similar)
☐ Vaccine management/handling and cold chain
☐ Data reporting and monitoring of service delivery (e.g. Data Quality Self-Assessment)
☐ Disease surveillance and reporting
☐ Injection safety and waste management
☐ Reaching Every District
☐ Training on new vaccines prior to introduction

1106b. Was immunization training carried out through formal training or supportive supervision?
☐ Formal training
☐ Supportive (on the job) training
☐ Mixture of formal and supportive (on the job) training
☐ No training

1107. Are the following items for immunization available in this service area today? ONLY SELECT ITEMS THAT ARE DIRECTLY OBSERVED AND PRESENT IN THE FACILITY
☐ Auto-disable syringes
☐ Sharps container/safety box
☐ Vaccine carrier(s)/cold box
☐ Set of ice packs for vaccine carriers (Note: 4-5 ice packs make one set)
☐ Immunization cards (or child health booklet)
☐ Official immunization tally sheets or integrated tally sheet
☐ Official immunization registers or equivalent

1108. Does this facility have a refrigerator AVAILABLE and FUNCTIONING for the storage of vaccines?
NOTE: FOR A REGRIGERATOR TO BE FUNCTIONAL IT MUST HAVE SUFFICIENT CAPACITY TO ACCOMMODATE ALL NEEDED VACCINES.
☐ Available and functional
☐ Available but not functional
☐ Available don't know if functioning
☐ None

1109. What type of energy source is used for the vaccine refrigerator?
☐ Electricity (grid or generator)
☐ Solar (with or without batteries)
☐ Other energy source (specify)

Please specify the other energy source?

1111. Which of the following devices for monitoring refrigerator temperature are AVAILABLE and FUNCTIONING in the facility today?
ASK TO SEE THE ITEMS
☐ Thermometer
☐ Continuous temperature recorder/logger

1112. Is the temperature of the refrigerator monitored twice daily? PLEASE ASK TO SEE THE LOG USED TO RECORD THE TEMPERATURE
☐ Yes ☐ No

1113. Has the temperature log been completed for the last 30 days?
PLEASE REVIEW LOG AND CHECK FOR COMPLETENESS (TEMPERATURE RECORDED 2 TIMES / DAY DURING THE LAST 30 DAYS)
☐ Yes ☐ No

1114. Has the temperature been OUTSIDE of the range 2° to 8°C inclusive in the last 30 days? PLEASE CHECK THE TEMPERATURE RECORD AND VERIFY THE TEMPERATURE FOR THE LAST 30 WORKING DAYS IN ORDER TO ANSWER THE QUESTION
☐ Observed in range
☐ Out of range
☐ Records not available

1115. Which of the following vaccines are available in this facility today?
☐ Measles vaccine and diluent
☐ DPT-Hib+HepB (pentavalent)
☐ Oral polio vaccine
☐ BCG vaccine and diluent
☐ Rotavirus vaccine
☐ Pneumococcal vaccine
☐ IPV (Inactivated polio vaccine)
☐ HPV (Human papillomavirus vaccine)
☐ Other vaccine (specify)
Which other vaccines are being offered?

1116. Are any of these vaccines EXPIRED (out of date)?
SELECT ONE OF EACH VACCINE AT RANDOM AND CHECK IF THE VACCINE IS VALID: 1. VIAL MONITOR ON THE VACCINE VIAL HAS NOT TURNED AND 2. THE EXPIRY DATE HAS NOT PASSED
☐ Measles vaccine and diluent
☐ DPT-Hib+HepB (pentavalent)
☐ Oral polio vaccine
☐ BCG vaccine and diluent
☐ Rotavirus vaccine
☐ Pneumococcal vaccine
☐ IPV (Inactivated polio vaccine)
☐ HPV (Human papillomavirus vaccine)
☐ Other vaccine (specify)
Which other vaccines are expired?

1117. In the past three months were you unable to give any of the vaccines listed below because of unavailable stock?
FOR EACH OF THE FOLLOWING ITEMS, PLEASE CHECK IN THE FACILITY RECORDS IF THERE HAS BEEN A STOCK- OUT IN THE PAST 3 MONTHS
☐ Measles vaccine and diluent
☐ DPT-Hib+HepB (pentavalent)
☐ Oral polio vaccine
☐ BCG vaccine and diluent
☐ Rotavirus vaccine
☐ Pneumococcal vaccine
☐ IPV (Inactivated polio vaccine)
☐ HPV (Human papillomavirus vaccine)
☐ Other vaccine (specify)

Which other vaccines were out of stock in the last 3 months?

» C. Child and adolescent health services

1200a. Which child and adolescent health services are offered by this facility?
☐ Child preventative and curative care services
☐ Adolescent health services
☐ Other (specify)

1200b. What other child and adolescent health services are offered by this facility?

424. » » i) Child preventative and curative care services

1201a. Which pediatric services are provided? Diagnose and/or treat child malnutrition Provide vitamin A supplementation
☐ Provide iron supplementation
☐ Provide ORS to children with diarrhoea
☐ Provide zinc supplementation to children with diarrhoea
☐ Child growth monitoring
☐ Treatment of pneumonia
☐ Administration of amoxicillin for the treatment of pneumonia in children
☐ Other (specify)

1201b. What other child preventative and curative care services are offered by this facility?

1202. Which child health documents are available in the facility today? ASK TO SEE THE DOCUMENT
☐ Integrated Management of Childhood Illnesses (IMCI) guidelines for the diagnosis and management of childhood illnesses
☐ National guidelines for growth monitoring
☐ Any check-lists and/or job-aids for Integrated Management of Childhood Illnesses (IMCI)

1203. Have staff received any child health training in the last two years?
☐ Curative care services for sick children and the Integrated Management of Childhood Illnesses (IMCI)
☐ Growth monitoring services for children

1204. I would like to know if the following basic equipment items are available in this service area today. For each equipment or item, only record if it is AVAILABLE today and FUNCTIONING.
☐ Length/height measuring equipment
☐ Growth charts

» » ii) Adolescent health services

1301. Do you have the national guidelines for service provision to adolescents available in this facility today? ASK TO SEE THE DOCUMENT
☐ Yes ☐ No

425. » D. Communicable diseases

1400a. Which communicable diseases services are offered by this facility?
☐ HIV (Human Imunodeficiency Virus) counselling & testing
☐ HIV (Human Imunodeficiency Virus) treatment
☐ HIV (Human Imunodeficiency Virus) care and support
☐ Sexually transmitted infections
☐ Tuberculosis Other (specify)

1400b. What other communicable diseases services are offered by this facility?

426. » » i) HIV (Human Imunodeficiency Virus) counselling & testing

1401. Do you have the national HIV counselling and testing guidelines available in this facility today? ASK TO SEE THE DOCUMENT
☐ Yes ☐ No

1402. Have staff received any HIV counselling and testing training in the last two years?
☐ Voluntary counselling and testing (VCT)
☐ HIV/AIDS prevention, care, and management for adolescents

1403. Does this facility provide HIV counselling and testing services to minor adolescents?
☐ Yes ☐ No

1404. Is the HIV testing and counselling service room or area a private room/area with auditory and visual privacy?
☐ Auditory privacy only
☐ Visual privacy only
☐ Both auditory and visual privacy
☐ No privacy

1405. Does this facility have HIV rapid test kits (with valid expiration date) in stock in this service site today? ONLY COUNT IF VALID (NOT EXPIRED)
☐ Yes ☐ No

1406. Does this facility have condoms available in this service site today to give to clients receiving services? ONLY COUNT IF VALID (NOT EXPIRED)
☐ Yes ☐ No

1407. Which basic equipment for infection control are available and functional in this department today. ONLY SELECT FUNCTIONAL EQUIPMENT
☐ Functional handwasing station
☐ Hand-washing soap / liquid soap
☐ Alcohol based hand rub
☐ Disposable latex gloves
☐ General waste receptacle (pedal bin) with lid and plastic bin liner
☐ Infectious waste receptacle (pedal bin) with lid and plastic bin liner
☐ Sharps container (“safety box”)
☐ Environmental disinfectant (e.g., chlorine, alcohol)
☐ Disposable syringes with disposable needles
☐ Auto-disable syringes

427. » E. Non-communicable diseases

2000a. Which non-communicable diseases services are offered by this facility?
☐ Diabetes
☐ Cardiovascular diseases
☐ Chronic respiratory diseases
☐ Cervical cancer
☐ Other (specify)

2000b. What other non-communicable diseases services are offered by this facility?

428. » » i) Diabetes

2002. Do you have the national guidelines for diagnosis and management of diabetes available in this facility today? ASK TO SEE THE DOCUMENT
☐ Yes ☐ No

2003. Have staff received any training in the diagnosis and management of diabetes in the last two years?
☐ Yes ☐ No

429. » » ii) Cardiovascular diseases

2005. Do you have the national guidelines for diagnosis and management of cardiovascular diseases available in this facility today?
ASK TO SEE THE DOCUMENT
☐ Yes ☐ No

2006. Have staff received any training in the diagnosis and management of cardiovascular diseases such as hypertension in the last two years?
☐ Yes ☐ No

430. » » iiii) Chronic respiratory diseases

2008. Do you have the national guidelines for the diagnosis and management of chronic respiratory diseases available in this facility today?
ASK TO SEE THE DOCUMENT
☐ Yes ☐ No

2009. Have staff received any training in the diagnosis and management of chronic respiratory diseases in the last two years?
☐ Yes ☐ No

2010. I would like to know if the following basic equipment items are available in this service area today. For each equipment or item, only record if it is AVAILABLE today and FUNCTIONING.
☐ Peak flow meters Spacers for inhalers

431. » » iv) Cervical cancer

2012. Do you have the national guidelines for cervical cancer prevention and control available in this facility today? ASK TO SEE THE DOCUMENT
☐ Yes ☐ No

2013. Have staff received any training in cervical cancer prevention and control in the last two years?
☐ Yes ☐ No

2014. I would like to know if the following basic equipment items are available in this service area today. For each equipment or item, only record if it is AVAILABLE today and FUNCTIONING.
☐ Acetic acid
☐ Speculum

432. » E. Surgical services

2100a. Which surgical services are offered by this facility?
☐ Surgery
☐ Blood transfusion
☐ Other (specify)

2100b. What other surgical services are offered by this facility?

433. » » i) Surgical services

2101a. Please tell me if this facility provides the following surgical services?
☐ Incision and drainage of abscesses
☐ Wound debridement
☐ Acute burn management
☐ Suturing
☐ Closed repair of fracture
☐ Cricothyroidotomy
☐ Male circumcision
☐ Hydrocele reduction
☐ Chest tube insertion
☐ Closed repair of dislocated joint
☐ Biopsy of lymph node or mass or other
☐ Removal of foreign body (throat, eye, ear or nose)

2101b. Please tell me if this facility provides the following surgical services?
☐ Tracheostomy
☐ Tubal ligation
☐ Vasectomy
☐ Dilatation & Curettage
☐ Obstetric fistula repair
☐ Episiotomy, cervical and vaginal laceration
☐ Appendectomy
☐ Hernia repair (strangulated)
☐ Hernia repair (elective)
☐ Cystostomy
☐ Urethral stricture dilatation
☐ Laparotomy (uterine rupture, ectopic pregnancy, acute abdomen, intestinal obstruction, perforation, injuries)
☐ Congenital hernia repair
☐ Neonatal surgery (abdominal wall defect, colostomy imperforate anus, intussusceptions)
☐ Cleft palate repair
☐ Contracture release
☐ Skin grafting
☐ Open reduction and fixation for fracture
☐ Amputation
☐ Cataract surgery
☐ Club foot repair (casting or open club foot release)
☐ Drainage of osteomyelitis-septic arthritis

2102a. Please tell me if the following surgical equipment and supplies are available and functional in this facility today. ONLY SELECT FUNCTIONAL EQUIPMENT
☐ Resuscitator bag and mask-adult
☐ Resuscitator bag and mask-paediatric
☐ Needle holder
☐ Scalpel handle with blades
☐ Retractor
☐ Surgical scissors
☐ Nasogastric tubes
☐ Tourniquet
☐ Suction pump (manual or electric) with catheter

2103. At any time during the past 3 months has oxygen been unavailable for any reason?
☐ Yes ☐ No

2104a. Which of the following materials or medicines are available in this service site today?
☐ Suture material (any type)
☐ Skin disinfectant
☐ Ketamine (injection)
☐ Lidocaine 1% or 2% (anaesthesia)
☐ Splints for extremities
☐ Material for cast

2104b. Are any of these materials or medicines EXPIRED (out of date)?
SELECT ONE OF EACH AT RANDOM AND CHECK IF THE EXPIRY DATE HAS PASSED
☐ Suture material (any type)
☐ Skin disinfectant
☐ Ketamine (injection)
☐ Lidocaine 1% or 2% (anaesthesia)
☐ Splints for extremities
☐ Material for cast

2105. Do you have materials on Integrated Management of Emergency and Essential Surgical care (IMEESC) (e.g. best practices, protocols, etc.) available in this facility today?
ASK TO SEE THE DOCUMENT
☐ Yes ☐ No

2106. Have staff received any training on Integrated Management of Emergency and Essential Surgical care (IMEESC) in the last two years?
☐ Yes ☐ No

2107. Does this facility have a staff member trained in surgery, including caesarean section, (clinical officer, general physician, or surgeon) present in the facility or on call 24 hours a day (including weekends and on public holidays)?
☐ Yes ☐ No

2108. Does this facility have a staff member trained in anaesthesia (nurse, clinical officer, general physician, surgeon, or anaesthesiologist) present in the facility or on call 24 hours a day (including weekends and on public holidays)?
☐ Yes ☐ No

2109. Which basic equipment for infection control are available and functional in this department today. ONLY SELECT FUNCTIONAL EQUIPMENT
☐ Functional handwasing station
☐ Hand-washing soap / liquid soap
☐ Alcohol based hand rub
☐ Disposable latex gloves
☐ General waste receptacle (pedal bin) with lid and plastic bin liner

☐ Infectious waste receptacle (pedal bin) with lid and plastic bin liner
☐ Sharps container ("safety box")
☐ Environmental disinfectant (e.g., chlorine, alcohol)
☐ Disposable syringes with disposable needles
☐ Auto-disable syringes

434. » » ii) Blood transfusion

2201. Have there been any interruptions in blood availability during the past 3 months?
☐ Yes ☐ No

2202. Does this facility obtain blood from a national or regional blood centre?
☐ Yes ☐ No

2203. Does this facility obtain ANY blood from sources other than the national or regional blood centre?
☐ Yes ☐ No

2204. Does any place in this facility do blood screening for infectious diseases prior to transfusion?
☐ Human Immunodeficiency Virus
☐ Syphilis
☐ Hepatitis B
☐ Hepatitis C
☐ No screening

2206. Does this facility have a refrigerator available and functioning in this service area for the storage of blood?
☐ Available and functional
☐ Available but not functional
☐ Available don't know if functioning
☐ None

2207. Is the temperature of the refrigerator monitored at least once every 24 hours? PLEASE ASK TO SEE THE LOG USED TO RECORD THE TEMPERATURE
☐ Yes ☐ No

2208. Has the temperature log been completed for the last 30 days?
PLEASE REVIEW LOG AND CHECK FOR COMPLETENESS (TEMPERATURE RECORDED 2 TIMES / DAY DURING THE LAST 30 DAYS)
☐ Yes ☐ No

2209. Has the temperature been OUTSIDE of the range 2° to 6°C inclusive in the last 30 days? PLEASE CHECK THE TEMPERATURE RECORD AND VERIFY THE TEMPERATURE FOR THE LAST 30 WORKING DAYS IN ORDER TO ANSWER THE QUESTION
☐ Observed in range
☐ Out of range
☐ Records not available

2210. Do you have any guidelines on the appropriate use of blood and safe transfusion practices? ASK TO SEE THE DOCUMENT
☐ Yes ☐ No

2211. Have staff received any training in the appropriate use of blood and safe transfusion practices in the last two years?
☐ Yes ☐ No

6. Diagnostics

3000. Does this facility conduct any diagnostic testing including any rapid diagnostic testing?
☐ Yes ☐ No

3100. Does this facility offer any of the following tests ON-SITE?
☐ Complete blood count (CBC);
☐ General urine analysis;
☐ Urine analysis according to Nechiporenko;
☐ General stool analysis;
☐ Collection of sputum samples for bacterioscopic examination;
☐ Microscopy of vaginal smear;
☐ Determination of blood clotting time;
☐ Biochemical blood analysis:
☐ determination of bilirubin, ALT, AST;
☐ determination of glucose;
☐ determination of cholesterol;
☐ C-reactive protein (CRP), ASLO, rheumatic tests (if available);
☐ determination of prothrombin index;

☐ determination of urea and creatinine;
☐ total protein;
☐ uric acid;
☐ Collection of samples for Hepatitis B and C testing;
☐ Collection of blood samples for HIV testing;
☐ Collection of blood samples for Wassermann reaction (RW);
☐ Collection of blood samples for malaria testing;
☐ Collection of blood samples for influenza testing;
☐ Collection of throat, nasal, pharyngeal, and other swabs for detection of infectious diseases;
☐ Collection of blood samples and swabs for other examinations.

3101. I would like to know if the following items for rapid diagnostic testing are available or not available today? CHECK TO SEE IF AT LEAST ONE OF EACH RAPID DIAGNOSTIC TEST IS VALID (NOT EXPIRED)
☐ Syphilis rapid test kit
☐ HIV rapid test kit
☐ Urine pregnancy test kit
☐ Dipsticks for urine protein
☐ Dipsticks for urine glucose
☐ Dipsticks for urine ketone bodies Filter paper for collecting DBS

3200. Does this facility conduct the following tests ON-SITE?
☐ Blood glucose tests using a glucometer
☐ Haemoglobin testing
☐ General microscopy/wet-mounts

3201. I would like to know if the following basic equipment items are available in this service area today. For each equipment or item, only record if it is AVAILABLE today and FUNCTIONING.
☐ Light microscope
☐ Glass slides and cover slips
☐ Refrigerator
☐ Glucometer
☐ Glucometer test strips (with valid expiration date)
☐ Colorimeter or haemoglobinometer
☐ HemoCue
☐ Incubator

3202. Does this facility have an accredited/certified microscopist?
☐ Yes ☐ No

3401. Does this facility conduct the following liver and renal function tests ON-SITE?
☐ ALT testing
☐ Other liver function testing (such as bilirubin)
☐ Serum creatinine testing
☐ Other renal function testing (such as urea nitrogen)

3402. I would like to know if the following basic equipment items are available in this service area today. For each equipment or item, only record if it is AVAILABLE today and FUNCTIONING.
☐ Biochemistry analyzer
☐ Centrifuge
☐ Specific assay kit(s)- liver function test
☐ Specific assay kit(s)- renal function test

3403. Does this facility do full blood count and differential testing ON-SITE?
☐ Yes ☐ No

3501. Does this facility conduct the following blood group serology tests ON-SITE?
☐ ABO blood grouping testing Rhesus blood grouping testing

3502. Please tell me if the following equipment items for blood group serology testing are available and functional today.
ASK TO SEE THE ITEMS
☐ Centrifuge
☐ 37° C incubator
☐ Grouping sera

3601. Does this facility conduct the following tests ON-SITE?
☐ Urine microscopy testing
☐ Syphilis serology testing
☐ Gram stain testing

3602. Please tell me if the following equipment items and reagents are available and functional today? ASK TO SEE THE ITEMS
☐ Specific assay kit- serum electrolyte test
☐ Specific assay kit- syphilis serology
☐ Gram stains
☐ White blood counting chamber
☐ Centrifuge
☐ Vortex mixer
☐ Pipettes
☐ Biochemistry analyzer

3603. Does this facility perform diagnostic x-rays, ultrasound, or computerized tomography?
☐ Yes ☐ No

3604. Please tell me if the following imaging equipment items are available and functional today. ASK TO SEE THE ITEMS
☐ X-ray machine
☐ Ultrasound equipment ECG

Medicines and commodities

4000. Does this facility stock medicines, vaccines, or contraceptive commodities?
☐ Infectious diseases medicines
☐ Non communicable diseases medicines
☐ Reproductive health commodities
☐ Maternal health medicines
☐ Cesarean section medicines and commodities
☐ Child health medicines
☐ Tuberculosis medicines
☐ Anti retroviral medicines
☐ Mental health and neurology medicines
☐ Palliative care medicines
☐ Other medicines and commodities

4001. Which of the following medicines for the treatment of INFECTIOUS DISEASES are OBSERVED to be available in this service site TODAY?
ONLY SELECT MEDECINES THAT ARE VALID (NOT EXPIRED)
☐ Co-trimoxazole cap/tab (Oral antibiotic)
☐ Fluconazole cap/tab
☐ Albendazole or Mebendazole cap/tab
☐ Metronidazole cap/tab
☐ Amoxicillin cap/tab
☐ Ceftriaxone injection
☐ Ciprofloxacin cap/tab

4002. Which of the following medicines for the treatment of NON-COMMUNICABLE DISEASES are OBSERVED to be available in this service site TODAY?
ONLY SELECT MEDECINES THAT ARE VALID (NOT EXPIRED)
☐ Metformin cap/tab
☐ Insulin regular injection
☐ Glucose 50% injection
☐ ACE inhibitor (e.g. enalapril, lisinopril, ramipril, perindopril)
☐ Thiazide (e.g. hydrochlorothiazide)
☐ Beta blocker (e.g.bisoprolol, metoprolol, carvedilol, atenolol)
☐ Calcium channel blocker (e.g. amlodipine)
☐ Aspirin cap/tab
☐ Beclomethasone inhaler
☐ Prednisolone cap/tab
☐ Hydrocortisone injection
☐ Epinephrine injection
☐ Furosemide cap/tab
☐ Glibenclamide cap/tab
☐ Gliclazide tablet or glipizide tablet
☐ Glyceryl trinitrate sublingual tablet
☐ Ibuprofen tablet
☐ Isosorbide dinitrate tablet
☐ Omeprazole tablet or alternative such as pantoprazole, rabeprazole
☐ Paracetamol cap/tab (adult oral formulation)
☐ Salbutamol inhaler
☐ Simvastatin tablet or other statin e.g. atorvastatin, pravastatin, fluvastatin Spironolactone tablets

4003. Are any of the following REPRODUCTIVE HEALTH medicines and commodities available in the facility TODAY? ONLY SELECT MEDECINES AND COMMODITIES THAT ARE VALID (NOT EXPIRED)
☐ Combined estrogen progesterone oral contraceptive pills
☐ Progestin-only contraceptive pills
☐ Combined estrogen progesterone injectable contraceptives
☐ Progestin-only injectable contraceptives
☐ Male condoms
☐ Female condoms
☐ Implant (e.g. levonorgestrel, etonogestrel)
☐ Emergency contraceptive pill (e.g. levonorgestrel tablet, ulipristal acetate tablet, mifepristone tablet 10-25 mg)
☐ Intrauterine contraceptive device (IUCD)

4005. Are any of the following MATERNAL HEALTH medicines and commodities available in the facility TODAY? ONLY SELECT MEDECINES AND COMMODITIES THAT ARE VALID (NOT EXPIRED)
☐ Iron tablets
☐ Folic acid tablets
☐ Iron and folic acid combined tablets
☐ Tetanus toxoid vaccine
☐ Sodium chloride injectable solution
☐ Calcium gluconate injection
☐ Magnesium sulphate injectable
☐ Ampicillin powder for injection
☐ Gentamicin injection
☐ Hydralazine injection
☐ Metronidazole injection
☐ Misoprostol 200µg tablets
☐ Azithromycin cap/tab or oral liquid
☐ Cefixime cap/tab
☐ Benzathine benzylpenicillin powder for injection
☐ Betamethasone injection
☐ Dexamethasone injection
☐ Nifedipine cap/tab (10mg)
☐ Methyldopa tablet
☐ Oxytocin injection

4007. Are any of the following CHILD HEALTH medicines and commodities available in the facility TODAY? ONLY SELECT MEDECINES AND COMMODITIES THAT ARE VALID (NOT EXPIRED)
☐ Procaine benzylpenicillin injection
☐ Oral Rehydration Salts (ORS) sachets
☐ Zinc sulphate tablets
☐ Zinc sulphate syrup or dispersible tablets
☐ Vitamin A (retinol) capsules
☐ Antibiotic eye ointment for newborn
☐ Co-trimoxazole syrup/suspension
☐ Paracetamol syrup/suspension
☐ Amoxicillin 250 mg or 500 mg dispersible tablet or syrup/suspension

4017. Are any of the following TUBERCULOSIS medicines available in the facility TODAY? ONLY SELECT MEDECINES THAT ARE VALID (NOT EXPIRED)
☐ Ethambutol
☐ Isoniazid
☐ Pyrazinamide Rifampicin
☐ Isoniazid + Rifampicin (2FDC)
☐ Isoniazid + Ethambutol (EH) (2FDC)
☐ Isoniazid + Rifampicin + Pyrazinamide (RHZ) (3FDC) Isoniazid + Rifampicin + Ethambutol (RHE) (3FDC)
☐ Isoniazid + Rifampicin + Pyrazinamide + Ethambutol (4FDC) Streptomycin injectable

4019. Are any of the following ANTI RETROVIRAL medicines or PROTEASE INHIBITORS available in the facility TODAY? ONLY SELECT MEDECINES THAT ARE VALID (NOT EXPIRED)
☐ Nevirapine (NVP)
☐ Nevirapine (NVP) syrup Efavirenz (EFV)
☐ Emtricitabine (FTC)
☐ Lamivudine + Abacavir (3TC + ABC)
☐ Zidovudine + Lamivudine (AZT + 3TC)
☐ Zidovudine + Lamivudine + Abacavir (AZT + 3TC + ABC)
☐ Zidovudine + Lamivudine + Nevirapine (AZT + 3TC + NVP)
☐ Tenofovir + Emtricitabine (TDF + FTC)
☐ Tenofovir + Lamivudine (TDF + 3TC)
☐ Tenofovir + Lamivudine + Efavirenz (TDF + 3TC + EFV)
☐ Tenofovir + Emtricitabine + Efavirenz (TDF + FTC + EFV)
☐ Didanosine (DDI)
☐ Lamivudine (3TC) syrup Stavudine 30 or 40 (D4T)
☐ Stavudine syrup
☐ Efavirenz (EFV) syrup
☐ Delavirdine (DLV)
☐ Enfuvirtide (T-20)
☐ Stavudine + Lamivudine (D4T + 3TC)
☐ Stavudine + Lamivudine + Nevirapine (D4T + 3TC + NVP)
☐ Lopinavir (LPV)
☐ Indinavir (IDV)
☐ Nelfinavir (NFV)
☐ Saquinavir (SQV)
☐ Ritonavir (RTV)
☐ Atazanavir (ATV)
☐ Fosamprenavir (FPV)
☐ Tipranavir (TPV)
☐ Darunavir (DRV)

4023. Are any of the following MENTAL HEALTH and NEUROLOGICAL medicines available in the facility TODAY? ONLY SELECT MEDECINES THAT ARE VALID (NOT EXPIRED)
☐ Amitriptyline tablet
☐ Carbamazepine tablet
☐ Chlorpromazine injection
☐ Diazepam tablet
☐ Diazepam injection or diazepam rectal tubes
☐ Fluoxetine tablet
☐ Fluphenazine injection
☐ Haloperidol tablet
☐ Lithium tablet
☐ Phenobarbital tablet
☐ Phenytoin tablet
☐ Valproate sodium tablet
☐ Lorazepam injection
☐ Levodopa + carbidopa tablet

4024. Are any of the following PALLIATIVE CARE medicines available in the facility TODAY? ONLY SELECT MEDECINES THAT ARE VALID (NOT EXPIRED)
☐ Dexamethasone injection
☐ Haloperidol injection
☐ Hyoscine butylbromide injection
☐ Lorazepam tablet
☐ Metoclopramide injection
☐ Morphine granules, tablet
☐ Morphine injection
☐ Senna preparation (laxative) Loperamide tab/cap

4022a. Are any of the following medicines or commodities for CESAREAN SECTION available in the facility TODAY? ONLY SELECT MEDECINES THAT ARE VALID (NOT EXPIRED)
☐ Thiopental (powder)
☐ Suxamethonium bromide (powder)
☐ Atropine (injection)
☐ Halothane (inhalation)
☐ Bupivacaine (injection)
☐ Lidocaine 5% (heavy spinal solution)
☐ Epinephrine (injection)
☐ Ephedrine (injection)

4022b. Are any of the following OTHER medicines or commodities available in the facility TODAY? ONLY SELECT MEDECINES THAT ARE VALID (NOT EXPIRED)
☐ Normal saline IV solution
☐ Ringers lactate IV solution
☐ 5% dextrose IV solution
☐ IV treatment for fungal infections
☐ Skin disinfectant
☐ Gowns
☐ Eye protection (goggles, face shields)
☐ Medical (surgical or procedural) masks
☐ Absorbable suture material
☐ Non-absorbable suture material
☐ Ketamine (injection)
☐ Lidocaine 1% or 2% (anaesthesia) Diazepam (injection)

Supply chain

4100a. Who is the principal person responsible for managing the ordering of medical supplies at this facility?
☐ Nurse
☐ Clinical officer
☐ Pharmacy technician
☐ Pharmacy assistant
☐ Pharmacist
☐ Medical assistant
☐ Other (specify)

4100b. Please specify the other responsible person?

4101. Which of the following mechanisms is used to determine this facility's resupply quantities?
☐ The facility itself (pull distribution system)
☐ A higher level facility (push distribution system)
☐ Other (specify)

4101b. Please specify the other distribution mechanism?

4102. How are the facility's resupply quantities determined?
☐ Formula
☐ Don't know
☐ Other means

4102b. Please specify the other method?

4103. What is the MAIN SOURCE of your routine pharmaceutical commodity supplies? By this I mean who is the direct supplier to your facility?
☐ National medical stores
☐ Joint medical stores
☐ Ngo/donors
☐ Private sources
☐ Other (specify)

4103b. Please specify the other resupply source?

4104. How are your pharmaceutical commodity supplies from the MAIN SUPPLIER of your routine pharmaceuticals delivered to this facility?
☐ Supplier delivers to facility
☐ Facility must arrange delivery to facility
☐ Other (specify)

4104b. Please specify the other delivery method?

4105. Who is responsible for transporting products from central medical stores to your facility?
☐ Local supplier delivers
☐ Higher level delivers
☐ This facility collects
☐ Other (specify)

4104b. Please specify the other transport method?

4106. For the most recent order, how long did it take between ordering and receiving products?
☐ Less than 2 weeks
☐ 2 weeks to 1 month
☐ Between 1 and 2 months
☐ More than 2 months

7. Interviewer's Observations

5000. Please use this space to add any other comments.

This is the end of the survey. Thank you for your support.

Appendix 'B' – List of Facilities Assessed

ID	Administrative territories	Name of the institution	Type of institution
1	Andijan region	Andijan city Family Polyclinic No. 3	FP
2		Andijan district Family Polyclinic No. 2	FP
3		Andijan district Konji Family Polyclinic	FP
4		Altynkol district Kumakay Family Polyclinic	FP
5		Bostan district Family Polyclinic No. 20	FP
6		Izboskan district Family Polyclinic No. 26	FP
7		Kurgan-Tepa district Family Polyclinic No. 56	FP
8		Ulug'nar district Family Polyclinic No. 40	FP
9		Marhamat district Polvontash Family Polyclinic	FP
10		Khojaabad district Family Polyclinic No. 60	FP
11		Shahrikhan district Family Polyclinic No. 67	FP
12		Karasuv city Multidisciplinary Central Polyclinic (MCP)	MCP
13		Andijan district Multidisciplinary Central Polyclinic	MCP
14		Bostan district Multidisciplinary Central Polyclinic	MCP
15		Jalaquduk district Multidisciplinary Central Polyclinic	MCP
16		Kurgan-Tepa district Multidisciplinary Central Polyclinic	MCP
17		Pakhtaabad district Multidisciplinary Central Polyclinic	MCP
18		Shahrikhan district Multidisciplinary Central Polyclinic	MCP
19		Asaka district Family Polyclinic No. 14	FP Type 1
20		Asaka district Family Polyclinic No. 18	FP Type 1
21		Asaka district Family Polyclinic No. 1	FP Type 2
22		Asaka district Family Polyclinic No. 3	FP Type 2
23		Asaka district family polyclinic No. 6	FP Type 2
24		Asaka district Family Polyclinic No. 8	FP Type 2
25		Asaka district Family Polyclinic No. 10	FP Type 2
26		Asaka district Family Polyclinic No. 12	FP Type 2
27		Asaka district Family Polyclinic No. 15	FP Type 2
28		Asaka district Family Polyclinic No. 2, Navruz branch	FP Type 2 branch
29		Asaka district Family Polyclinic No. 12, Otish branch	FP Type 2 branch
30		Asaka district Family Polyclinic No. 8, Lower Tuvadok branch	FP Type 2 branch

31		Bukhara city Family Polyclinic No. 8	FP
32		Olot district Family Polyclinic No. 29, Muxtor	FP
33		Karakul district Family Polyclinic No. 57, Kuvvacha	FP
34		Peshku district Family Polyclinic No. 35, Talisobun	FP
35		Kogon district Family Polyclinic No.23, Geophysicists	FP
36		Bukhara district Family Polyclinic No. 4, Yurunbolo	FP
37		Vobkent district Family Polyclinic No. 12, Kumushkent	FP
38		Shafirkan district Family Polyclinic No. 47, Boghiafzal	FP
39		Jondor district Family Polyclinic No. 19, N. Rajabov	FP
40		Kogon city Multidisciplinary Central Polyclinic	MCP
41		Karakul district Multidisciplinary Central Polyclinic	MCP
42		Kogon district Multidisciplinary Central Polyclinic	MCP
43		Bukhara district Multidisciplinary Central Polyclinic	MCP
44		Shafirkan district Multidisciplinary Central Polyclinic	MCP
45	Bukhara region	Gijduvan district Family Polyclinic No. 13	FP Type 1
46		Gijduvan district Family Polyclinic No. 15	FP Type 1
47		Gijduvan district Family Polyclinic No. 18	FP Type 1
48		Gijduvan district Family Polyclinic No. 20	FP Type 1
49		Gijduvan district Family Polyclinic No. 22	FP Type 1
50		Gijduvan district Family Polyclinic No. 24	FP Type 1
51		Gijduvan district Family Polyclinic No. 26	FP Type 1
52		Gijduvan district Family Polyclinic No. 28	FP Type 1
53		Gijduvan district Family Polyclinic No. 31	FP Type 1
54		Gijduvan district Family Polyclinic No. 1	FP Type 2
55		Gijduvan district Family Polyclinic No. 3	FP Type 2
56		Gijduvan district Family Polyclinic No. 5	FP Type 2
57		Gijduvan district Family Polyclinic No. 7	FP Type 2
58		Gijduvan district Family Polyclinic No. 8	FP Type 2
59		Gijduvan district Family Polyclinic No. 10	FP Type 2
60		Gijduvan district Family Polyclinic No. 12	FP Type 2

61	Fergana region	Fergana city Family Polyclinic No. 3	FP
62		Kokand city Family Polyclinic No. 7	FP
63		Margilan city Family Polyclinic No. 4	FP
64		Kuvasoy city Family Polyclinic No. 3	FP
65		Baghdad district Family Polyclinic No. 4	FP
66		Baghdad district Family Polyclinic No. 102	FP
67		Buvayda district Family Polyclinic No. 24	FP
68		Dangara district Family Polyclinic No. 31	FP
69		Rishton district Family Polyclinic No. 49	FP
70		Toshlok district Family Polyclinic No. 56	FP
71		Uchkuprik district Family Polyclinic No. 61	FP
72		Furkat district Family polyclinic No. 66	FP
73		Yozyavon district Family polyclinic No. 36	FP
74		Fergana city Multidisciplinary Central Polyclinic	MCP
75		Margilan city Multidisciplinary Central Polyclinic	MCP
76		Beshariq district Multidisciplinary Central Polyclinic	MCP
77		Dangara district Multidisciplinary Central Polyclinic	MCP
78		Sokh district Multidisciplinary Central Polyclinic	MCP
79		Uzbekistan district Multidisciplinary Central Polyclinic	MCP
80		Furkat district Multidisciplinary Central Polyclinic	MCP
81		Kuva district Family Polyclinic No. 16	FP Type 1
82		Kuva district Family Polyclinic No. 18	FP Type 1
83		Kuva district Family Polyclinic No. 21	FP Type 1
84		Kuva district Family Polyclinic No. 1	FP Type 2
85		Kuva district Family Polyclinic No. 3	FP Type 2
86		Kuva district Family Polyclinic No. 5	FP Type 2
87		Kuva district Family Polyclinic No. 7	FP Type 2
88		Kuva district Family Polyclinic No. 9	FP Type 2
89		Kuva district Family Polyclinic No. 11	FP Type 2
90		Kuva district Family Polyclinic No. 13	FP Type 2

91	Jizzakh region	Jizzakh city Family Polyclinic No. 4	FP
92		Bakhmal district Family Polyclinic No. 6	FP
93		Sharof Rashidov district Family Polyclinic No. 23	FP
94		Zafarabad district Family Polyclinic No. 12	FP
95		Jizzakh city Multidisciplinary Central Polyclinic	MCP
96		Do'stlik district Multidisciplinary Central Polyclinic	MCP
97		Zamin district Multidisciplinary Central Polyclinic	MCP
98		Zafarabad district Multidisciplinary Central Polyclinic	MCP
99		Forish district Multidisciplinary Central Polyclinic	MCP
100		Gallaorol district Family Polyclinic No. 7	FP Type 1
101		Gallaorol district Family Polyclinic No. 9	FP Type 1
102		Gallaorol district Family Polyclinic No. 11	FP Type 1
103		Gallaorol district Family Polyclinic No. 13	FP Type 1
104		Gallaorol district Family Polyclinic No. 15	FP Type 1
105		Gallaorol district Family Polyclinic No. 18	FP Type 1
106		Gallaorol district Family Polyclinic No. 20	FP Type 1
107		Gallaorol district Family Polyclinic No. 22	FP Type 1
108		Gallaorol District Family Polyclinic No. 2	FP Type 2
109		Gallaorol district Family Polyclinic No. 4	FP Type 2
110		Gallaorol district Family Polyclinic No. 1, Tomchi	FP Type 2 branch
111		Gallaorol district Family Polyclinic No. 1, Yangiyul	FP Type 2 branch
112		Gallaorol district Family Polyclinic No. 4, Khojakobud	FP Type 2 branch
113		Gallaorol district Family Polyclinic No. 4, Oqtash	FP Type 2 branch
114		Gallaorol district Family Polyclinic No. 4, Nurafshon	FP Type 2 branch

115	Namangan region	Namangan city Family Polyclinic No. 3	FP
116		Namangan city Family Polyclinic No. 17	FP
117		Yangi Namangan district Family Polyclinic No. 16	FP
118		Namangan district Family Polyclinic 12, Galcha	FP
119		Yangikurgan district Family Polyclinic No. 60, Bekabad	FP
120		Uchkurgan district Family Polyclinic No. 42, Yashiqobod	FP
121		Pop district Family Polyclinic No. 20, Iskovut	FP
122		Mingbulak district Family Polyclinic No. 8, Gortepa	FP
123		Kosonsoy district Family Polyclinic No. 6, Navbahor	FP
124		Chust district Family Polyclinic No. 49, G'ova	FP
125		Namangan city Multidisciplinary Central Polyclinic	MCP
126		Yangi Namangan district Multidisciplinary Central Polyclinic	MCP
127		Yangikurgan district Multidisciplinary Central Polyclinic	MCP
128		Uychi district Multidisciplinary Central Polyclinic	MCP
129		Mingbulak district Multidisciplinary Central Polyclinic	MCP
130		Chust district Multidisciplinary Central Polyclinic	MCP
131		Chartok district Family Polyclinic No. 10, Ziyokor	FP Type 1
132		Chartak district Family Polyclinic No. 13, Qarabagh	FP Type 1
133		Chartok district Family Polyclinic No. 15, Saroy	FP Type 1
134		Chortok District Family Polyclinic No. 17, Beshtol	FP Type 1
135		Chartak district Family Polyclinic No. 19, Baghistan	FP Type 1
136		Chartok district Family Polyclinic No. 2, Ayqiron	FP Type 2
137		Chartok district Family Polyclinic No. 3, Muchum	FP Type 2
138		Chortoq district Family Polyclinic No. 5, Chortoq	FP Type 2
139		Chartok district Family Polyclinic No. 7, Alikhon	FP Type 2
140		Chartok district Family Polyclinic No. 9, Baliq ko‘l	FP Type 2

141		Navoi city Family Polyclinic No. 3	FP
142		Karmana district Family Polyclinic No. 40	FP
143		Navbahor district Family Polyclinic No. 9	FP
144		Kyzyltepa district Family Polyclinic No. 16	FP
145		Kyzyltepa district Family Polyclinic No. 23	FP
146		Zarafshan city Multidisciplinary Central Polyclinic	MCP
147		Tomdi district Central Multidisciplinary Polyclinic	MCP
148		Karmana district Multidisciplinary Central Polyclinic	MCP
149		Nurota district Multidisciplinary Central Polyclinic	MCP
150	Navoi region	Khatirchi district Family Polyclinic No. 2	FP Type 1
151		Khatirchi district Family Polyclinic No. 10	FP Type 1
152		Khatirchi district Family Polyclinic No. 13	FP Type 1
153		Khatirchi district Family Polyclinic No. 15	FP Type 1
154		Khatirchi district Family Polyclinic No. 17	FP Type 1
155		Khatirchi district Family Polyclinic No. 19	FP Type 1
156		Khatirchi district Family Polyclinic No. 21	FP Type 1
157		Khatirchi district Family Polyclinic No. 24	FP Type 1
158		Khatirchi district Family Polyclinic No. 26	FP Type 1
159		Khatirchi district Family Polyclinic No. 28	FP Type 1
160		Khatirchi district Family Polyclinic No. 30	FP Type 1
161		Khatirchi district Family Polyclinic No. 32	FP Type 1
162		Khatirchi district Family Polyclinic No. 1	FP Type 2
163		Khatirchi district Family Polyclinic No. 4	FP Type 2
164		Khatirchi district Family Polyclinic No. 7	FP Type 2
165		Khatirchi district Family Polyclinic No. 12	FP Type 2

166		Karshi district Family Polyclinic No. 53	FP
167		Guzar district Family Polyclinic No. 44	FP
168		Kamashi district Family Polyclinic No. 49	FP
169		Koson district Bulmas Family Polyclinic	FP
170		Karshi city Family Polyclinic No. 6	FP
171		Mirishkor district Family Polyclinic No. 26	FP
172		Shahrisabz district Family Polyclinic No. 33	FP
173		Kokdala district Family Polyclinic No. 61	FP
174		Karshi district Multidisciplinary Central Polyclinic	MCP
175		Kasbi district Multidisciplinary Central Polyclinic	MCP
176		Kamashi district Multidisciplinary Central Polyclinic	MCP
177		Dehqanabad district Multidisciplinary Central Polyclinic	MCP
178		Yakkabagh district Multidisciplinary Central Polyclinic	MCP
179		Kokdala district Multidisciplinary Central Polyclinic	MCP
180	Kashkadarya region	Kitab district Family Polyclinic No. 10	FP Type 1
181		Kitab district Family Polyclinic No. 12	FP Type 1
182		Kitab district Family Polyclinic No. 14	FP Type 1
183		Kitab district Family Polyclinic No. 18	FP Type 1
184		Kitab district Family Polyclinic No. 22	FP Type 1
185		Kitab district Family Polyclinic No. 24	FP Type 1
186		Kitab district Family Polyclinic No. 26	FP Type 1
187		Kitab district Family Polyclinic No. 28	FP Type 1
188		Kitab district Family Polyclinic No. 1	FP Type 2
189		Kitab district Family Polyclinic No. 3	FP Type 2
190		Kitab district Family Polyclinic No. 5	FP Type 2
191		Kitab district Family Polyclinic No. 7	FP Type 2
192		Kitab district Family Polyclinic No. 9	FP Type 2
193		Kitab district Family Polyclinic No. 9, Yukory Ayoqchi	FP Type 2 branch
194		Kitab district Family Polyclinic No. 7, Siyob	FP Type 2 branch
195		Kitab district Family Polyclinic No. 6, Aspidukhtar	FP Type 2 branch
196		Kitab district Family Polyclinic No. 6, Denovbola	FP Type 2 branch

197	Republic of Karakalpakstan	Nukus city Family Polyclinic No. 6	FP
198		Tortkul district Family Polyclinic No. 40	FP
199		Tortkul district Family Polyclinic No. 47	FP
200		Amudarya district Family Polyclinic No. 1	FP
201		Amudarya district Family Polyclinic No. 71	FP
202		Ellikkal'a district Family Polyclinic No. 66	FP
203		Shumanay district Family Polyclinic No. 59	FP
204		Kun'git district Shumanay district No. 23	FP
205		Kegeyli district Shumanay district No. 29	FP
206		Karauzak district Family Polyclinic No. 21	FP
207		Tortkul district Multidisciplinary Central Polyclinic	MCP
208		Amudarya district Multidisciplinary Central Polyclinic	MCP
209		Shumanay district Multidisciplinary Central Polyclinic	MCP
210		Khojaly district Multidisciplinary Central Polyclinic	MCP
211		Kegeyli district Multidisciplinary Central Polyclinic	MCP
212		Karauzak district Multidisciplinary Central Polyclinic	MCP
213		Takhiatash district Multidisciplinary Central Polyclinic	MCP
214		Chimboy district Family Polyclinic No. 4	FP Type 1
215		Chimboy district Family Polyclinic No. 7	FP Type 1
216		Chimboy district Family Polyclinic No. 9	FP Type 1
217		Chimboy district Family Polyclinic No. 11	FP Type 1
218		Chimboy district Family Polyclinic No. 1	FP Type 2
219		Chimboy district Family Polyclinic No. 1, Branch No. 1	FP Type 2 branch
220		Chimboy district Family Polyclinic No. 1, Branch No. 2	FP Type 2 branch

221	Samarkand region	Aqdarya district Family Polyclinic No. 19, Dahbed	FP
222		Kattakurgan district Family Polyclinic No. 10, Kattaming	FP
223		Pakhtachi district T. Kenjayev Family Polyclinic	FP
224		Samarkand district Ohalik Family Polyclinic	FP
225		Urgut district Shodlik Family Polyclinic	FP
226		Akdaryo district Multidisciplinary Central Polyclinic	MCP
227		Kattakurgan district Multidisciplinary Central Polyclinic	MCP
228		Samarkand district Multidisciplinary Central Polyclinic	MCP
229		Urgut district Multidisciplinary Central Polyclinic	MCP
230		Samarkand city Family Polyclinic No. 20	FP Type 1
231		Bulungur district Family Polyclinic No. 13	FP Type 1
232		Bulungur district Family Polyclinic No. 16	FP Type 1
233		Bulungur district Family Polyclinic No. 18	FP Type 1
234		Ishtikhon district Family Polyclinic No. 14	FP Type 1
235		Ishtikhon district Family Polyclinic No. 16	FP Type 1
236		Ishtikhon district Family Polyclinic No. 23	FP Type 1
237		Ishtikhon district Family Polyclinic No. 15	FP Type 1
238		Samarkand city Family Polyclinic No. 2	FP Type 2
239		Samarkand city Family Polyclinic No. 8	FP Type 2
240		Samarkand city Family Polyclinic No. 10	FP Type 2
241		Samarkand city Family Polyclinic No. 14	FP Type 2
242		Bulungur district Family Polyclinic No. 1	FP Type 2
243		Bulungur district Family Polyclinic No. 2	FP Type 2
244		Bulungur district Family Polyclinic No. 8	FP Type 2
245		Ishtikhon district Family Polyclinic No. 3	FP Type 2
246		Ishtikhon district Family Polyclinic No. 9	FP Type 2
247		Bulungur district Family Polyclinic No. 10, branch 1	FP Type 2 branch
248		Bulungur district Family Polyclinic No. 10, branch 2	FP Type 2 branch
249		Ishtikhon district Family Polyclinic No. 3	FP Type 2 branch
250		Ishtikhon district Family Polyclinic No. 2	FP Type 2 branch
251		Ishtikhon district Family Polyclinic No. 8	FP Type 2 branch

252	Syrdarya region	Guliston city Family Polyclinic No. 2 – Experimental Primary Health Care Polyclinic	FP
253		Boyovut district Family Polyclinic No. 7	FP
254		Gulistan district Family Polyclinic No. 15	FP
255		Saykhunabad district Family Polyclinic No. 23	FP
256		Yangiyer city Multidisciplinary Central Polyclinic	MCP
257		Oqoltin district Multidisciplinary Central Polyclinic	MCP
258		Mirzaabad district Multidisciplinary Central Polyclinic	MCP
259		Sardoba district Multidisciplinary Central Polyclinic	MCP
260		Syrdarya district Family Polyclinic No. 6	FP Type 1
261		Syrdarya district Family Polyclinic No. 9	FP Type 1
262		Syrdarya district Family Polyclinic No. 11	FP Type 1
263		Syrdarya district Family Polyclinic No. 14	FP Type 1
264		Syrdarya district Family Polyclinic No. 1, branch 1	FP Type 1
265		Syrdarya district Family Polyclinic No. 1	FP Type 2
266		Syrdarya district Family Polyclinic No. 3	FP Type 2
267		Syrdarya district Family Polyclinic No. 13	FP Type 2 branch
268		Syrdarya district Family Polyclinic No. 1, branch 2	FP Type 2 branch
269		Syrdarya district Family Polyclinic No. 2, branch	FP Type 2 branch

270	Surkhandarya region	Termez city Family Polyclinic No. 7	FP
271		Oltinsay district Family Polyclinic No. 60, Sayrak	FP
272		Muzrabod district Family Polyclinic No. 49, Navbahor	FP
273		Kumkurgan district Family Polyclinic No. 37, Sh. Mirzayev	FP
274		Termez district Family Polyclinic No. 70, Do'stlik	FP
275		Sherabad district Family Polyclinic No. 85, Uzbekistan	FP
276		Shurchi district Family Polyclinic No. 92, Polvontash	FP
277		Altynsay district Multidisciplinary Central Polyclinic	MCP
278		Muzrabad district Central Multidisciplinary Polyclinic	MCP
279		Sariosiyo district Multidisciplinary Central Polyclinic	MCP
280		Sherabad district Multidisciplinary Central Polyclinic	MCP
281		Bandikhon district Multidisciplinary Central Polyclinic	MCP
282		Denov district Family Polyclinic No. 18	FP Type 1
283		Denov district Family Polyclinic No. 20	FP Type 1
284		Denov district Family Polyclinic No. 23	FP Type 1
285		Denov district Family Polyclinic No. 25	FP Type 1
286		Denov district Family Polyclinic No. 27	FP Type 1
287		Denov district Family Polyclinic No. 29	FP Type 1
288		Denov district Family Polyclinic No. 31	FP Type 1
289		Denov district Family Polyclinic No. 33	FP Type 1
290		Denov district Family Polyclinic No. 2	FP Type 2
291		Denov district Family Polyclinic No. 4	FP Type 2
292		Denov district Family Polyclinic No. 6	FP Type 2
293		Denov district Family Polyclinic No. 8	FP Type 2
294		Denov district Family Polyclinic No. 10	FP Type 2
295		Denov district Family Polyclinic No. 12	FP Type 2
296		Denov district Family Polyclinic No. 13	FP Type 2
297		Denov district Family Polyclinic No. 15	FP Type 2
298		Denov district Family Polyclinic No. 2, Olamjakhon	FP Type 2 branch
299		Denov district Family Polyclinic No. 2, Bogishamol	FP Type 2 branch
300		Denov district Family Polyclinic No. 7, Pojur	FP Type 2 branch

301	Tashkent city	Mirabad district Family polyclinic No. 1	FP
302		Mirzo Ulugbek district Family Polyclinic No. 9	FP
303		Uchtepa district Family Polyclinic No. 62	FP
304		Almazar district Family Polyclinic No. 14	FP
305		Almazar district Family Polyclinic No. 21	FP
306		Shaykhontohur district Family Polyclinic No. 46	FP
307		Chilanzor district Family Polyclinic No. 37	FP
308		Yunusabad district Family Polyclinic No. 54	FP
309		Yakkasaray district Family Polyclinic No. 60	FP
310		Yashnabad district Family Polyclinic No. 32	FP
311		Mirzo Ulugbek district Medical Association - Multidisciplinary Central Polyclinic	MCP
312		Sergeli district Medical Association - Multidisciplinary Central Polyclinic	MCP
313		Shaykhontohur district Medical Association - Multidisciplinary Central Polyclinic	MCP
314		Yakkasaroy district Medical Association - Multidisciplinary Central Polyclinic	MCP
315		Yashnabad district Medical Association - Multidisciplinary Central Polyclinic	MCP

316		Almalyk city Family Polyclinic No. 1	FP
317		Bekabad city Family Polyclinic No. 1	FP
318		Bekabad district Family Polyclinic No. 2	FP
319		Buka district Family Polyclinic No. 9	FP
320		Zangiota district Family Polyclinic No. 17	FP
321		Tashkent district Family Polyclinic No. 21	FP
322		Kibray district Madaniyat Family Polyclinic	FP
323		Oqqu'rgan district Family Polyclinic No. 34	FP
324		Parkent district Family Polyclinic No. 42	FP
325		Parkent district Krasnogorsk Family Polyclinic	FP
326		Orta-chirchik district Family Polyclinic No. 55	FP
327	Tashkent region	Chinaz district Family Polyclinic No. 62	FP
328		Yangiyul district Family Polyclinic No. 70	FP
329		Nurafshon city Multidisciplinary Central Polyclinic	MCP
330		Angren city Multidisciplinary Central Polyclinic	MCP
331		Ahangaran city Multidisciplinary Central Polyclinic	MCP
332		Buka district Multidisciplinary Central Polyclinic	MCP
333		Zangiota district Multidisciplinary Central Polyclinic	MCP
334		Kuyi-chirchik district Multidisciplinary Central Polyclinic	MCP
335		Ahangaran district Multidisciplinary Central Polyclinic	MCP
336		Pskent district Multidisciplinary Central Polyclinic	MCP
337		Chinaz district Multidisciplinary Central Polyclinic	MCP
338		Yangiyul city Family Polyclinic No. 1	FP Type 2

339	Khorezm region	Khiva city Family Polyclinic No. 1	FP
340		Bogat district Family Polyclinic No. 7	FP
341		Gurlan district Family Polyclinic No. 14	FP
342		Koshkopir district Family Polyclinic No. 22	FP
343		Urgench district Family Polyclinic No. 29	FP
344		Hazorasp district Family Polyclinic No. 37	FP
345		Khiva district Family Polyclinic No. 44	FP
346		Yangiarik district Family Polyclinic No. 60	FP
347		Urgench city Multidisciplinary Central Polyclinic	MCP
348		Khiva city Multidisciplinary Central Polyclinic	MCP
349		Kushkupir district Multidisciplinary Central Polyclinic	MCP
350		Hazorasp district Multidisciplinary Central Polyclinic	MCP
351		Khanka District Multidisciplinary Central Polyclinic	MCP
352		Yangibazar district multidisciplinary central polyclinic	MCP
353		Shovot district Family Polyclinic No. 11	FP Type 1
354		Shovot district Family Polyclinic No. 13	FP Type 1
355		Shovot district Family Polyclinic No. 15	FP Type 1
356		Shovot district Family Polyclinic No. 17	FP Type 1
357		Shovot district Family Polyclinic No. 1	FP Type 2
358		Shovot district Family Polyclinic No. 3	FP Type 2
359		Shovot district Family Polyclinic No. 4	FP Type 2
360		Shovot district Family Polyclinic No. 6	FP Type 2
361		Shovot district Family Polyclinic No. 8	FP Type 2
362		Shovot district Family Polyclinic No. 8, Gulshan	FP Type 2 branch